

Doing professionalism 'differently':  
Negotiating midwifery autonomy in  
Aotearoa/New Zealand

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## Abstract

This thesis examines how midwives have been doing professionalism in Aotearoa/New Zealand since gaining the legal right to practise independently of doctors in 1990. It analyses midwifery autonomy as a complex and contingent outcome of a competitive political process involving key groups of actors in the health/maternity field. Unlike approaches that regard professional status simply as an outcome of an occupation's organisational structure or political strategising, this account seeks to tease out some of the complexities involved in the relational construction of professional positioning. In the process it shows how midwifery has been able to utilise gender, profession/state and profession/consumer relations as resources in its efforts to obtain and consolidate an autonomous status vis a vis nursing and medicine.

In examining the professionalising strategies of midwives, attention is paid to the role played by state actors in enhancing or diminishing the jurisdiction that a profession has over an area of work that is constituted as 'expert' practice. This is demonstrated in the thesis in relation to both the granting of midwifery autonomy and the subsequent introduction of fixed-fee funding for primary maternity services. These policy changes had significant implications for midwifery and medical autonomy, forms of practice and relations with clients. Discussion of how the change in funding arrangements created opportunities for midwifery to consolidate its jurisdiction over 'normal' childbirth highlights the significance for professions of aligning their interests with broader political and economic objectives.

Analysis of how midwifery has been constituted by midwives and maternity consumers as a form of feminist professional practice based on 'partnership' shows how particular constructions of gender and expertise can be used as discursive resources in the

struggle over autonomy. Doing professionalism according to this 'new' model of practice involves positioning midwives as autonomous practitioners vis a vis other health professionals but as 'partners' with maternity consumers. It is argued in the thesis that a distinction between 'old' and 'new' forms of professionalism should be seen as a false dichotomy. While 'new' professionalism may provide the basis for more equitable professional/client relations, it also supports an alternative claim to 'expertise' and autonomy.

Professionalism should be understood as socially situated, both in practice and discursively, and as subject to interpretation and redefinition. Rather than conceptualising a shift from one model or ideal-type of professionalism ('old') to another ('new'), it is argued that different forms of professionalism exist simultaneously and can be strategically utilised by professions in ongoing contestation and negotiation over professional status. How a profession uses its knowledge base as a resource in claiming jurisdiction over work that it constructs as a form of 'expert' practice is variable. Opportunities for doing professionalism 'differently' are contingent on a profession's embeddedness in networks of relations with state actors, clients and other professions.

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## Acronyms and Abbreviations

ACMI	Australian College of Midwives
ADN	Advanced Diploma of Nursing
AHB	Area Health Board
AIT	Auckland Institute of Technology
ARM	Association of Radical Midwives (England)
ASIM	Australian Society of Independent Midwives
CHE	Crown Health Enterprise
CIS	Carcinoma in situ (cervical cancer)
CNM	Certified Nurse-Midwife (United States)
DEM	Direct Entry Midwifery
DOH	Department of Health
DOMINO	Domiciliary Midwives In and Out (of hospital)
GMS	General Medical Services benefit
HBA	Home Birth Associations
HBL	Health Benefits Limited
HCP	Health Care Plans
HFA	Health Funding Authority
HRD	Health Reforms Directorate
ICM	International Confederation of Midwives
IPA	Independent Practitioner Association

LMC	Lead Maternity Care provider
MANA	Midwives' Alliance of North America
MBS	Maternity Benefit Schedule
MGP	Midwifery Group Practice (England)
MPO	Midwifery Provider Organisation
MPS	Maternity Payment Schedule
NAA	Nurses Amendment Act 1990
NHC	National Health Committee
NHS	National Health Service (England)
NZCOM	New Zealand College of Midwives
NZMA	New Zealand Medical Association
NZNA	New Zealand Nurses' Association
NZNO	New Zealand Nurses' Organisation
NZQA	New Zealand Qualifications Authority
OECD	Organisation for Economic Cooperation and Development
PEAC	Professional External Advisory Committee
RHA	Regional Health Authority
RNZCGP	Royal New Zealand College of General Practitioners
RNZCOG	Royal New Zealand College of Obstetricians and Gynaecologists

SOEs	State Owned Enterprises
SRHA	Southern Regional Health Authority
THA	Transitional Health Authority
WHO	World Health Organisation



*The first night we used the surgeons' lounge it was hilarious - they have all these photos of old plastic surgeons on the wall. The midwives took all the photos off their hooks and put up their posters of breastfeeding and various other things. Because they were doing their next antenatal class the following evening they decided to leave the posters up and just hang the old men over the top. Well, at 8:30 the next morning, we had the secretary from plastics up here saying 'What would Mr MacIndoe say? He was sitting in the lap of a breastfeeding woman!'. We just rolled around in laughter. So we unhooked Mr MacIndoe and took all the breastfeeding women down. But the midwives found that the glass on the portraits is good for blue tac so they stick their posters from nose to nose of the old men. It's like the worm has turned....*

*- Practice Manager, Burwood Birthing Services (1994)*

## Part One

### Conceptualising autonomy: midwifery and professionalism

## **Chapter One**

### **Introducing the case**

Case studies of professions are both the raw material of the theory and the audience that says thumbs up or down (Abbott, 1988: 31).

#### **1.1 Introduction**

Midwifery was in the news when research for this thesis began. It was three years after the Nurses Amendment Act and the introduction of midwifery autonomy, but the struggle between midwives and doctors for control over childbirth was still very much in the public eye. Newspaper and magazine articles (eg. McLoughlin, 1993; Laracy, 1.4.93; Schultz, 9.6.93; Munro, 25.6.93) reported regularly on disputes between the two professions over issues of safety, responsibility and income.<sup>1</sup> These articles also recorded the fact that significant changes were taking place in the way that midwives practised and women/clients were choosing to give birth. There was anecdotal and statistical evidence to show that independent or self-employed midwives were making inroads into the traditionally doctor-dominated arena of primary maternity care.

Midwifery therefore presented as an interesting and topical area for sociological research. How midwives were positioning themselves as independent birthing practitioners in a context of health sector restructuring became the focus of investigative work for this thesis. Interviews and documentary research began to build up a picture of developments in the maternity field. With important changes taking place in both

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<sup>1</sup> Details of newspaper and magazine articles cited throughout the thesis are included in the references and a separate appendix of media sources.

independent and hospital-based forms of midwifery/maternity practice, and in midwives' relations with clients, doctors and state actors, the research project had a strong substantive focus. But what were its possibilities as a 'case' for examining the relationship between gender and professionalism? This question was addressed as theoretical ideas from a variety of literatures were considered in relation to aspects of the empirical findings.

Before identifying key themes that emerged from an on-going interplay between theoretical ideas and empirical findings, it is important to be more specific about the approach to the 'case' in this research (Ragin and Becker, 1992). This approach involved making the process through which the case itself is constructed, the object of study (discussed later in this chapter). By making midwifery professionalism/autonomy the focus of investigation and explanation, as opposed to treating it as a given, a major objective of the research became "the discovery of what exactly the end result is" (Becker, 1992: 209). In this approach, the case is regarded as a complex and contingent outcome of a process that needs to be identified and explained. This form of analysis involves constructing a story about the case and how it came to take a particular form.

The case study method or format provides a means of examining the richness and complexity of how actual organisational outcomes occur. Theoretical insights or explanations come out of empirical analysis of the everyday workings of social institutions, rather than being abstracted from them. In midwifery's case, the empirical findings provided the basis for engagement with a number of key themes within the sociology of professions. Discussion of this literature and its relevance to the research project is the focus of chapter two. However, it can be seen from the following introduction to the themes, that the professional project of midwives in contemporary

Aotearoa/New Zealand provides a strategic site for examining how professional expertise or autonomy is the outcome of a competitive political process.<sup>2</sup>

An important theme that has been neglected in mainstream (malestream) theorising on the professions (Abbott, 1988; Freidson 1970, 1973, 1986, 1994; Larson, 1977, 1990; Johnson, 1972, 1982) is the relationship between gender and professional status.<sup>3</sup> As a study of a predominantly (almost exclusively) female occupational group which has recently secured legal jurisdiction over its training and practice, this research/thesis contributes to an understanding of the ways in which professional projects are gendered processes.<sup>4</sup> Analysis of how midwifery is constituted by some midwives and their maternity consumer supporters as a form of feminist professional practice shows how particular constructions of gender can be used as a cultural resource in the struggle to obtain and consolidate autonomous status.

A related theme is the attention to relations within the medical/health division of labour. Some research in this area (eg. Riska and Wegar, 1993; Lorber, 1997) has focussed on a pattern of sex segregation of medical/health work by gender. This literature examines the dominance of the medical profession (predominantly male/masculine) over a hierarchy of relations in which female practitioners, both within medicine and in allied

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<sup>2</sup> The concept of 'professional project' will be explained in chapter two. It is used in this thesis to highlight the fact that a profession, like midwifery in Aotearoa/New Zealand, is an entity whose members have to work at bringing into existence. This project involves a variety of practices directed at maintaining and, if possible, enhancing the position of 'the profession'. See Macdonald (1995) for discussion of professions as 'projects'.

<sup>3</sup> The work of feminist writers (Crompton, 1987, 1990; Stacey, 1988; Witz, 1986, 1990, 1992, 1994; Davies, 1995, 1996) who have critiqued this gender-blind approach to theorising professions is discussed in chapter two.

<sup>4</sup> While the Human Rights Act 1993 precludes discrimination against men in terms of entry to midwifery training and practice, there have only ever been a small number of registered male midwives. Registration data shows there were nine registered male midwives in late 1995 (Guilliland, 1998: 62) with only two men registering as midwives in the previous seven years. It is unlikely that these men, who would have been registered nurses who completed the postgraduate midwifery diploma, actually practised as midwives. The post 1990 shift to direct entry midwifery training, with its focus on 'women-centred' care and feminist practice, makes it even less likely that men will either choose, or be selected for, midwifery training.

health occupations, are segregated into occupational/professional niches characterised by little prestige or autonomy. Examining how midwifery is putting autonomy into practice in Aotearoa/New Zealand prompts consideration of how, in specific social and political contexts, this arrangement of the medical/health field can be challenged.

This point highlights another theme which is the contingency of a profession's jurisdiction or control over a particular area of 'expert' work. Analysis of the struggle between doctors and midwives throughout this century for control over childbirth shows how forms of professional control change over time, largely as a consequence of changes in state/government policies. An examination of how jurisdiction over maternity work came to be dominated by doctors in the 1930s, and opened up to midwives in the 1990s, provides an opportunity for analysing how professional expertise or autonomy is the outcome of a competitive political process involving a complex combination of occupational strategies, state policies and shifts in public opinion.

A concern with the relationship between professions and the state is another major theme from the sociology of professions that this research addresses. As both a licensing authority and a source of funding, the state can enhance or diminish the control that an occupation or profession has at any given time over the provision of particular services (Torstendahl, 1990a; Burrage, 1990a). The importance of recognising the role that the state plays in shaping professional jurisdictions is highlighted in discussion of the implications for midwives and doctors of the strategies adopted over the last decade to contain spending within the health/maternity sector. Midwifery's opportunities for autonomous practice have arisen out of the interest state actors have in providing more flexible, cost effective and consumer-oriented primary maternity services.

Another theme relates to the type of knowledge base that a profession has and how it is used to legitimate a particular form of practice. Sociological literature on the professions (eg. Larson, 1977; Freidson, 1986; Abbott, 1988) recognises in various ways the importance of systematically and rationally based knowledge in making claims to professional status. Claims to cognitive exclusivity over/in a particular knowledge base are used to secure control or jurisdiction over the provision of certain 'expert' services in a market. How this knowledge base is constituted, and used as a resource for advancing a profession's interests, is contingent on a variety of factors including its relations with the state, clients and the activities of competing professions.

This case study also provides a strategic site for examining how an occupational group strategically deploys a particular construction of 'expertise' in making claims over an area of professional work. Analysis of midwifery's claims to expertise shows how they are used to justify and defend a form of autonomous practice in which the professional/client relationship is redrawn. Rather than displacing 'expertise', these claims underpin a different form of professional practice that has been identified (Davies, 1995; Williams, 1993; Stacey, 1992) as 'new professionalism'. Examining how midwifery is putting this 'new' form of expertise into practice highlights the importance of understanding the relations and practices within which different claims to knowledge and skill are embedded.

Before looking in more detail at the professional project of midwives in contemporary Aotearoa/New Zealand, it is important to set the case in an international context. Discussion of the professional status of midwifery in various western countries shows that there is considerable diversity not only between countries, but also between groups of midwives within particular countries. This diversity relates to differences in forms of recruitment, training and styles of practice as well as in professional status and rewards. As DeVries (1993:132) observed:

If we organized midwives along a continuum, with those who use all the tools of modern technology at one end and those who are non-technological in orientation at the other, those on the extreme ends of the continuum would not recognise each other as members of the same occupation.

## 1.2 The international context

When Caroline Flint, the president of the Royal College of Midwives in the United Kingdom, visited Aotearoa/New Zealand in 1994 she paid tribute to the achievement of local midwives. Speaking at the opening of the New Zealand College of Midwives' (NZCOM) conference in Rotorua, she said that midwives in New Zealand were "held up as an example throughout the world". In making this comment Flint was not just referring to the fact that midwives in Aotearoa/New Zealand had regained the right to practice independently of doctors. She was also referring to the fact that an independent midwife could claim payment from the state for her services on the same basis as general practitioners. This made the independent or self-employed midwife in Aotearoa/New Zealand the "best paid midwife in the world".<sup>5</sup>

As an independent midwife in the UK, Flint did not have the advantage of being able to claim payments from the state for the services she provided. Like other midwives who left the National Health Service (NHS) in the mid-1980s to set up in independent practice, she could only provide domiciliary midwifery care to fee-paying clients (Isherwood, 1995; Robinson, 1990).<sup>6</sup> While free homebirth care was available on the NHS, independent midwives attracted those clients who wanted continuity of midwifery care and as little intervention as possible during pregnancy and labour

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<sup>5</sup> At the time this comment was made, primary maternity services were funded on a fee-for-service basis. This 'open-ended' payment system enabled some independent midwives, with particularly big caseloads, to earn large incomes (an issue discussed in chapter five).

<sup>6</sup> In the mid 1980s there were 10 midwives practising independently in Britain. By 1990 the number had increased to 32 midwives and by 1994 there were an estimated 100 midwives.



(Isherwood, 1995: 31). Research showed that the independent midwives' fees were relatively low and were a compromise between what the midwife deserved, what she could live on, and what a client could reasonably be expected to pay (Leap, 1991).

Flint's comments highlight the variable status of independent midwifery in different countries. While midwives in the UK have the legal right to practise independently, they are not entitled to claim state benefits as an independent health professional. For this, and other reasons associated with the historical development of the profession (Donnison, 1977; Oakley, 1984; Towler and Bramall, 1986; Robinson, 1990), the majority of midwives work as salaried employees within the NHS providing fragmented and supervised maternity care. While efforts were made throughout the 1980s to set up schemes which made greater use of midwives' knowledge and skills, researchers note that midwives' responsibilities for clinical assessment and decision-making concerning the management of women's care continue to be restricted by doctors (Robinson, 1990; Allison and Pascall, 1994; Dingwall et al., 1988; Kirkham, 1986).

Further opportunities for midwives working within the NHS to pursue initiatives with regard to autonomous midwifery services have arisen over the last five years as a consequence of government reviews of public maternity services. These reviews, which form part of a broader strategy to reform the NHS that began in the 1980s (Bartlett and Harrison, 1993; Ranade, 1994; Klein, 1995), recommended that a 'medical model of care' should no longer drive the maternity service and that women be given more opportunity to exercise choice in the type of care that they receive (Jenkins, 1995; Symonds and Hunt, 1996; Sandall, 1996a).<sup>7</sup> A key document produced by the Expert Maternity Group called *Changing Childbirth* (Department of Health, 1993)

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<sup>7</sup> Discussion of similarities between NHS reforms and Aotearoa/New Zealand health reforms, particularly with regard to changes in the funding and provision of primary health services, is included in chapter five.

recommended that women have more control over their care and that greater use be made of midwives' skills.<sup>8</sup>

Commentators suggest that the shift away from a centralised/administered health system to one based on a funder/provider split and the contracting of competing health providers may create opportunities for midwifery to (re)present itself as a flexible and cost-effective form of primary maternity care. Isherwood argued (1995: 38) that by contracting into the NHS, midwives could achieve professional autonomy similar to that of general practitioners and dentists. This argument endorses the claim made by DeVries (1993: 136) that the success of midwifery as an autonomous occupation is closely tied to the structural arrangements for the payment of services. In a cross-national analysis of the status of midwives, he stated that decisions by governments and private insurance companies determine the terms of existence for midwives.

This point is further illustrated by looking at the position of midwives in countries such as Sweden and the Netherlands where the maternity-care systems are decentralised (even though, in the case of Sweden, the health system as a whole is nationalised). In these countries midwives have retained aspects of autonomy that their colleagues in the more centralised systems of Britain, Canada and the United States have lost (Benoit, 1991; DeVries, 1993). In both Sweden and the Netherlands, midwives practise independently of doctors as long as pregnancies/births show no indication of obstetrical complication (van Teijlingen and van der Hulst, 1995). While most maternity care in

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<sup>8</sup> As a consequence of this report, NHS authorities were required to ensure that the following "key indicators of success" were met within five years: every woman should know one midwife who ensures continuity of midwifery care, at least 30 percent of women should have the midwife as the lead professional, every woman should know the lead professional who has a key role in the planning and provision of her care, at least 75 percent of women should know the person who cares for them during their delivery, midwives should have direct access to some beds in all maternity units and at least 30 percent of women delivered in a maternity unit should be admitted under the management of the midwife. Continuity of care provided by group practices/teams of midwives has been advocated as one way to achieve these indicators. See Allen et al. (1997) for research on the setting up of midwifery group practice (MGP) pilot projects by some regional health authorities.

Sweden is provided at neighbourhood 'mothercare centres' which are government funded and staffed by midwives, Dutch midwives practise within a fee-for-service system.

While a fee-for-service payment system is an attractive financial proposition for some medical/health practitioners, it can also have its disadvantages. According to Benoit (1991:137), this payment system hinders the professional status of Dutch midwives. She claimed that it isolates midwives, makes them compete for clients, provides little opportunity for career advancement and forces them into an unpredictable round-the-clock work schedule. By contrast, Sweden's midwives have a steady flow of clients, interaction with colleagues and well-defined career ladders. These differences highlight the relationship between funding arrangements and professional status. Details of payment regimes can have major consequences for midwifery 'autonomy', forms of practice and relations with clients and other practitioners (see chapter five).

The significance of the connection between funding arrangements and forms of autonomous midwifery practice is further illustrated by the status of certified nurse-midwives (CNMs) in the United States.<sup>9</sup> The CNMs who practise within the 'managed care' health system are reliant on having their services financed by insurance companies. According to DeVries (1985, 1993), government recognition in the form of a licence does not guarantee the flourishing of midwifery. His research showed that while a midwife might be licensed, her viability as a health professional is uncertain if insurance companies do not pay for her services. This relation between insurance and midwifery could work in the occupation's favour, however, as companies looking for more economical approaches to health care might favour midwives' services (DeVries, 1993: 137).

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<sup>9</sup> The number of practising CNMs in the United States has risen from approximately 400 in 1971 to 6,347 in 1995. The number of births attended by CNMs rose from 19,686 in 1975 to 188,370 in 1993. See Bear (1996).

Literature on North American midwifery (Burtch, 1994; Rushing, 1993; Benoit, 1991; Langton, 1991; Katz Rothman, 1991; Sullivan and Weitz, 1988; DeVries, 1985) distinguishes between CNMs, who are closely associated with obstetrical nursing, and community/independent (sometimes called 'lay') midwives who are associated with homebirthing and have a more precarious legal status. While CNMs are qualified to provide "independent management of care", they usually work under the auspices of an obstetrical practice and deliver babies only in a hospital (Holland, 1998; Lorber, 1997: 39). Lay midwives often have formal training from an independent midwifery school and/or an apprenticeship to another midwife but their practice is "clearly legal" in only ten states (Rushing, 1993: 48).

Like their colleagues in the United Kingdom, some CNMs are looking to take advantage of changes in the health care system to "restructure and reframe" the way they provide care (Bear, 1996). Instead of focusing exclusively on attending to pregnancy and childbirth, they are looking to specialise more broadly in women's primary health care. As well as providing 'interconceptual care', which includes annual physicals, breast examinations, pap smears and all types of family planning, CNMs are extending their practice to include gynaecological care of 'well women' throughout their life cycle. Emphasis in their practice is put on continuity of care, non-intervention in normal processes, health promotion and safe, competent clinical management.<sup>10</sup>

According to Rushing (1993: 50), nurse-midwifery in Canada has never attained the level of legitimacy, in terms of state approval and acceptance by hospitals, that it has in the United States. She said that market factors in Canada do not provide strong support

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<sup>10</sup> It is interesting to note this development in nurse-midwifery in the U.S given DeVries' argument (1993: 144) that midwives' attempts to seek a niche in modern medical systems by claiming to be experts in 'low-risk' birth threaten their credibility as a professional group. He claims that prestige and power are given to those who manage high-risk situations, not to those who attend low-risk births. I comment on this claim in the concluding chapter.

for nurse midwifery in that national health insurance, a low birth rate and a surplus of physicians and nurses combine to constrain nurse-midwives' professional development. However, independent midwifery has done "fairly well" in both countries despite its uncertain legal status.<sup>11</sup> Rushing's research showed how independent midwives have drawn support from the women's health movement and maternity consumer groups in claiming legitimacy for their woman/family centred style of domiciliary midwifery practice.

Collaborating with maternity consumer groups in an effort to secure recognition of midwifery autonomy has also been a strategy adopted by independent midwives in Australia (Lecky-Thompson, 1995). While midwives have the right to practise autonomously in some states, only a small number choose to provide independent care for women having home births (Skelly, 1996). Of the approximately 200,000 births annually in Australia, about 1000 babies are born at home with care provided by approximately 100 independent midwives, some of whom are unregistered (Lecky-Thompson, 1995: 41-42). Given that there are about 10,000 practising midwives in the country, those working independently constitute a very small group within the profession.

Lecky-Thompson, a member of the Australian Society of Independent Midwives, attributed the lack of support for independent midwifery to medical dominance, antagonism by the nursing profession and ignorance within the community about the role of a midwife (1995: 41).<sup>12</sup> Despite there not being a "wide and genuine" range of

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<sup>11</sup> In 1993 independent midwifery was legally recognised in only 10 states but was not "clearly illegal" in most other states and Canadian provinces (Rushing, 1993: 50). According to Burtch (1994: 11), midwives in Canada were in an anomolous situation " at best, alegal; at worst, subject to inquests, inquiries, trials and penalties". In 1998 there were 125 registered midwives practising in Ontario, the first province to fund midwifery care through its health ministry. These midwives delivered 2-3 percent of Ontario's approximately 148,000 annual births (Wolgelerenter, 1998).

<sup>12</sup> The Australian Society of Independent Midwives (ASIM) was set up in August 1989, about the same time as the NZCOM was formed. It was modelled on the Association of Radical Midwives (ARM) in the UK and the Midwives' Alliance of North America

options available for maternity consumers, the support for independent midwifery is not as strong as it was a decade ago. According to Lecky-Thompson (1995: 57), this is because childbirth consumer groups are "struggling for survival" as few people see the need for such lobbying mechanisms. The availability of midwifery care through Medicare-funded birthing centres has also diffused the support for independent midwifery services.

The situation in Australia is therefore similar to that in other countries where the system of funding maternity services provides a financial disincentive for consumers to opt for independent midwifery care. By making independent midwives reliant on attracting fee-paying clients for their livelihood, these funding arrangements also discourage midwives from choosing this form of practice. For midwives in some countries there is greater financial security, if not greater professional satisfaction, in being employed to provide midwifery care within a publicly-funded health system. This is particularly the case in countries where a medicalised, hospital-oriented approach to maternity care prevails and choosing the services of an independent midwife for a homebirth is still regarded as a marginal and risky choice.

As this summary of the professional status of midwives in various western countries shows, there is considerable diversity not only between countries but also between groups of midwives within particular countries. This diversity reflects a variety of understandings about what a 'midwife' is (more or less inclusive definitions) which are associated with different discourses about pregnancy and childbirth and different sets of relations between midwives and doctors in the health care division of labour. While Dutch midwives, for example, are independent practitioners responsible for the regulation of their own profession and practice, midwives in other countries are

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(MANA). The professional voice for the majority of Australian midwives, who are employed in hospitals, is the Australian College of Midwives (ACMI) which began in 1979.

struggling in different ways to have their skills and services recognised. This diversity highlights the fact that professional status is a social product which is subject to the influence of structural arrangements and cultural ideas.

Recognition of the contingency of professional status highlights the need to analyse the professional projects of midwives in the specific cultural, political and historical contexts in which they are located. While there are features that are common to the national organisation of health in various countries, there are also specific policies and arrangements which impact significantly on the position of professional groups vis a vis each other in the health care division of labour. As this discussion has shown, a key factor in determining the professional status of midwifery in a particular country is the structural arrangement for the payment of services. Where midwifery has legal autonomy but is not state-funded, the majority of midwives continue to play a subordinate role in the provision of maternity services.

This is not to suggest that midwifery's professional fortunes, in any given place at any given time, rest entirely on structural/economic factors. Of considerable importance are changes in societal understandings about how, and by whom, maternity services should be provided. Cultural understandings of concepts such as 'childbirth', 'midwifery' and 'autonomy' are produced in political and professional discourses and institutionalised in maternity practices. Opportunities for these understandings to be contested or defended by groups of actors - embedded in networks of relations within the state, professions or public arena - arise in particular institutional and historical contexts. The nature or direction of any change that occurs in the professional status of midwifery is influenced by what cultural/discursive resources are available - and to whom.

The changes that have occurred in the professional status of midwifery in Aotearoa/New Zealand over the last decade can be seen as an outcome of this complex interplay between structural and cultural factors. Opportunities for groups of politically active midwives, maternity consumers and state actors to challenge both the medical profession's influence over the meaning of childbirth, and its legal jurisdiction over the provision of services, have arisen in a context of major restructuring of public health services. Key actors within these groups have drawn on changing cultural understandings about the nature of childbirth and professional/client relations, and New Right discourses about the need to break professional monopolies.

In gaining the legal right to practise independently of doctors, and claim maternity benefits from the state for the provision of services, midwives in Aotearoa/New Zealand have come to occupy a central position in a publicly-funded maternity system. Unlike some of their counterparts overseas who practise independently but are limited to providing domiciliary services in the private health sector, midwives in Aotearoa/New Zealand are able to offer a full range of primary maternity services. This means that they can compete with doctors for maternity clients and/or contracts. However, unlike their counterparts who have a history of professional independence, they are newcomers to establishing a distinct and autonomous sphere of competence for themselves within the health division of labour. While their expertise has been recognised in law, their jurisdictional claims over maternity work continue to be worked out in practice.

### **1.3 Midwifery in Aotearoa/New Zealand**

Midwifery in Aotearoa/New Zealand has undergone a dramatic change in professional status over the last decade. As a consequence of the Nurses Amendment Act 1990 and restructuring of the funding and provision of health/maternity services, midwifery has



emerged as a profession in its own right. After decades of working under the legal jurisdiction of doctors, as specialist/obstetric nurses, midwives regained the right to practise independently. As autonomous birthing practitioners, midwives can assume responsibility for the provision of antenatal, birthing and postnatal care in a client's home, medical/birthing centre or hospital. They can also, for the first time, prescribe and administer certain prescription medicines commonly used in pregnancy and childbirth.

As well as being able to practise autonomously, midwives have the right to claim from the state for the maternity services they provide. Access to the fee-for-service maternity benefit, on the same basis as general practitioners, enabled a significant proportion of practising midwives to give up their hospital employment and set up in independent practice. This meant that within three years of gaining legal autonomy approximately 350 of the 1700 practising midwives in Aotearoa/New Zealand were working independently (McLoughlin, 1993: 56).<sup>13</sup> As independent practitioners, these midwives could provide care either in their own right or in a 'shared' arrangement with a general practitioner or obstetrician. The majority of independent midwives offer a 'domino' birthing option in which they provide antenatal and postnatal care in the client's home and assist with her birth in hospital (Guilliland, 1998).

Following changes made in mid-1996 to the way primary maternity services are funded, midwives and doctors now vie for selection as a woman's lead maternity care provider (LMC).<sup>14</sup> A practitioner who becomes the LMC effectively holds the budget

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<sup>13</sup> NZCOM membership lists show that by 1994 approximately 450 midwives, or 23 percent of the midwifery workforce, identified themselves as independent or self-employed. This figure increased to 500 (25 percent) in 1995, 586 (30 percent) in 1996 and 591 in 1997. Some self-employed midwives could still work part-time in hospital employment. See Guilliland (1998).

<sup>14</sup> Under section 51 of the Health and Disability Services Act 1993, which came into effect on July 1 in 1996, the funding of maternity care changed from a fee-for-service to a fixed-fee system. According to this funding arrangement, the former Regional Health Authorities (RHAs) contracted with midwives, general practitioners and specialists (obstetricians) to

for a pregnant woman's maternity care and is responsible for either providing all the required services or sub-contracting part of the care to another practitioner. Under this new framework, a midwife may provide all the care herself or sub-contract with a doctor to provide 'shared' care if that is what the woman chooses. Midwives are also employed in hospitals (or Crown Health Enterprises (CHEs) as they were called between 1993 and 1998) to provide antenatal, birthing and/or postnatal care on either a rostered or, more commonly, a caseload/continuity basis.

As autonomous birthing practitioners, midwives in Aotearoa/New Zealand occupy a central position in the publicly-funded maternity system. Self-employed and hospital-employed midwives are able to offer a full range of primary maternity services within and across a variety of institutional settings. Embedded in both competitive and collaborative relations with general practitioners and obstetricians, midwives constitute a key group of providers within the 'quasi' or internal market that has been introduced into the health sector. As providers/practitioners with an interest in securing a niche within this market, they are engaged in on-going struggles to establish the distinctiveness and desirability of autonomous midwifery care. As noted earlier, midwifery expertise has been recognised in law, but its jurisdiction over primary maternity work continues to be worked out in practise.

A key strategy in this jurisdictional struggle over the provision of primary maternity services has been the adoption of an unorthodox model of professional practice. As the title of this thesis suggests, midwives can be seen as doing professionalism 'differently' than most other professional groups. The word 'differently' is enclosed in inverted commas for several reasons. On the one hand, it can be argued that there are multiple and diverse ways of doing professionalism, therefore there is no common or essential mode from which to depart. However, it can also be argued that the claims to

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provide primary maternity services on a budget-holding basis. These issues are discussed in chapter five.

expertise and autonomy made by midwifery do differ in some significant respects both to the claims that midwives made in previous decades and to the claims made by other professional groups in the contemporary context. These differences relate to alternative understandings about the nature of professional knowledge/skill and how it can be used to support or underpin more equitable professional/client relations.

In claiming jurisdiction over normal/primary childbirth, midwifery in Aotearoa/New Zealand has reconstituted itself as a feminist form of professional practice (Tully et al., 1998). Central to this feminist form of practice is the concept of 'partnership' between midwives as female health professionals and women who share their understanding of childbirth as a normal life event (Pairman, 1998; Guilliland and Pairman, 1995). This 'partnership' between midwives and consumers, which developed out of mutually supportive relations between domiciliary midwives and homebirth consumers in the 1970s/80s, was formalised in the philosophy of the NZCOM which was formed in 1989. Despite opposition from the International Confederation of Midwives (ICM), consumers were given membership rights.<sup>15</sup>

As members of the college, consumers attend regional meetings and can participate in all policy and decision-making. Three consumer representatives - from Parents' Centre, La Leche League and Maternity Action Alliance - belong to the 18-member national committee.<sup>16</sup> An example of the college's commitment to consumer representation is the fact that it covers the costs involved in these representatives attending meetings, which are held three times a year in various parts of the country. Consumers also play a

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<sup>15</sup> After threatening to expel New Zealand for its stance on consumer membership of the NZCOM, the confederation in 1993 adopted a policy statement (submitted by the NZCOM) which acknowledged midwifery to be a profession "which is based upon partnership between women and midwives".

<sup>16</sup> Four members of the committee are representatives of a Maori midwives' organisation, Nga Maia O Aotearoa me te Waipounamu. The NZCOM supported the establishment of a separate organisation for Maori midwifery which worked alongside the college in advancing the position and practice of midwifery in Aotearoa/New Zealand within a bicultural framework.

significant role in two important forums within the college where midwifery practice comes under scrutiny - the midwifery standards review committees and the regional resolutions committees. Of particular significance are the standards review committees which have been set up throughout the country to review the practice of all college midwives with caseloads (ie. those working as 'independent' or, more accurately, self-employed practitioners).

The blueprint for these committees was the review process developed by the Auckland Home Birth Association in 1988 to monitor the practice of domiciliary midwives. The association initiated this process in response to moves by hospital boards to review the practice of home birth midwives (Interview, Pot: 3.2.94). Following the Nurses Amendment Act and the upsurge in numbers of self-employed midwives, many of whom offered domiciliary care, association members became involved in organising reviews of independent midwives' practice in conjunction with the NZCOM. The first review committee consisted of three college-endorsed midwives (an independent midwife, a hospital midwife, and one from either form of employment) and three consumers endorsed by the Maternity Services Consumer Council.<sup>17</sup>

By 1998 there were twenty-five review committees, consisting of equal numbers of midwives and consumers, throughout Aotearoa/New Zealand (Guilliland, 1998: 87). Self-employed midwives are required to be reviewed annually for three consecutive years. If their practice meets the standards set down by the NZCOM they are then required to present for a formal review every 2-3 years. However, they still have to submit a written record/account of their previous year's practice, including a statistical breakdown of their clients' outcomes, to the committee coordinator who may request a

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<sup>17</sup> According to documentation on the midwives' standards review process, a consumer representative should be both a consumer/user of maternity services and someone who is actively involved in community based work on maternity issues with links and connections to consumer groups.

review (Pot, 1994).<sup>18</sup> The aim of the review process is to give a midwife the opportunity to reflect on her practice, evaluate her performance and identify areas requiring development.

In contrast to the practitioner-focussed standards review committees are the consumer-focussed regional resolutions committees. These committees, which consist of a midwife and a consumer, provide a place for women to access information and a second opinion on their pregnancy/birthing experiences. Neither the standards review committees nor the regional resolutions committees have a punitive role. Complaints about a midwife's practice are dealt with by regional complaints committees, which consist of an equal number of midwives and consumers. If the complaint is not resolved through mediation at the local level, it can be referred on to the college's national quality assurance coordinator.<sup>19</sup> If still unresolved, it may then be referred on to the preliminary proceedings committee of the Nursing Council which will decide if there is a case to answer.<sup>20</sup> If the Nursing Council finds a midwife guilty of the charges laid, she may be publically censured, fined, required to practice under supervision or struck off for one year.<sup>21</sup>

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<sup>18</sup> A midwife's review process also involves consideration of evaluation forms completed by her clients between six weeks and three months after the birth. These forms are sent by the consumer directly to the local branch of the NZCOM where they are read by an independent person nominated by the coordinator of the review committee before being forwarded on to the midwife. The consumer can choose whether she wants her midwife to read her evaluation form.

<sup>19</sup> The NZCOM cannot award compensation, punitive damages or deregister a midwife. It can only revoke college membership.

<sup>20</sup> The Nursing Council of New Zealand is the statutory authority for nurses and midwives with legislated functions under the Nurses Act 1977 (and subsequent amendments) and the Nurses Regulations 1986. Following the Nurses Amendment Act 1990, the NZCOM has a representative on the council. The college is hopeful that a Midwives Act will be passed to legally separate midwifery from nursing and enable the establishment of a Midwives' Council to govern the profession's practice, education and discipline. The nurses' professional organisation, the New Zealand Nurses Organisation (NZNO), favours a new Nurses and Midwives Act based on similar principles to the Medical Practitioners Act 1995. This would involve a move to competency-based annual practicing certificates and the creation of a new disciplinary tribunal, separate from the Nursing Council. See chapter four.

<sup>21</sup> Considerable publicity was given to the case of Jean O'Neil, a Hutt Valley midwife who was struck off the register of midwives by the Nursing Council in June 1998. The council had

Another significant way that partnership is put into practise is through direct entry midwifery (DEM) training. The curricula for these polytechnic-based courses, which began on an experimental basis as a consequence of the Nurses Amendment Act 1990, had considerable consumer input. A draft curriculum for DEM training was produced in 1990 by the Save the Midwives Direct Entry Task Force which was co-ordinated by a consumer health activist. This curriculum, which was drawn up following extensive consultation with women and those involved in the provision of maternity services, provided the basis for the first DEM degree/diploma programmes (see chapter four). Maternity consumers continue to be involved in the running of these courses through representation on professional external advisory committees (PEACs).<sup>22</sup>

In adopting this 'partnership' model of practice, midwives in Aotearoa/New Zealand can be seen as acting on ideas/claims associated with "new professionalism" (Williams, 1993; Stacey, 1992). This model of professionalism, which posits more equitable, interdependent relations between professionals and clients/patients than those associated with a more 'traditional' model, is being debated internationally in relation to attempts by occupational groups such as nursing and social work to secure professional autonomy over their work (Davies, 1995; Hugman, 1991).<sup>23</sup> These occupational groups, which have historically been regarded as 'semi' professions, share concerns regarding the implications for predominantly female occupations of professionalism

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found her guilty of five charges of professional misconduct relating to the birth and death of a baby boy in 1996. O'Neil could continue to practise as a nurse but under supervision for a year.

<sup>22</sup> For example, the Professional External Advisory Committee for the midwifery degree programme offered at Christchurch Polytechnic since 1997 has four maternity consumer members. They represent Parents Centre, La Leche League, the Home Birth Association and Tipu Ora.

<sup>23</sup> Hugman (1991) uses the term 'democratic' in his discussion of a model of professionalism for the 'caring' professions in which the issue of power is made explicit. It will be argued in this thesis that this term is preferable to 'new' professionalism in that it does not suggest such discontinuity between a previous model and the reformed one.

based on a rational, scientific, instrumental, and arguably masculinist, approach to knowledge.

Concern about the relevance of 'old' style professionalism is not limited to those writers with an interest in the direction taken by subordinate professions such as nursing and social work. In arguing that the medical profession must abandon "old-style professionalism", Stacey (1992) claimed that patients are increasingly unprepared to accept the subservient position medicine has historically afforded them. She urged doctors to listen to what patients say and to understand the way they see things ie. their conceptual framework. Other writers (eg. Greenwood and Lachman, 1996) noted the changing status of professional knowledge and the formation of "downstream alliances" between professional organisations and their clientele.<sup>24</sup>

Researching midwifery in contemporary Aotearoa/New Zealand provides an opportunity to analyse the claims and practices associated with this alternative approach to professionalism; an approach in which the professional/client relationship is reconstituted as a 'partnership' in which each partner contributes to the negotiated outcome. This involves the strategic deployment of new and different claims to knowledge/expertise which position midwives as autonomous practitioners vis a vis other health professionals, particularly doctors, but as 'partners' in their relations with clients/consumer representatives. This research provides an opportunity to examine both the advantages and the tensions for midwifery in its attempt to adopt such a professional position.

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<sup>24</sup> Discussion of this literature and claims associated with 'new professionalism' appears in chapter two.

## 1.4 Constructing midwifery as an object of study

In constructing midwifery in contemporary Aotearoa/New Zealand as an object of study, this thesis combines a concern with both the relational and discursive construction of professional projects and identities. This dual focus is achieved by combining aspects of contemporary theorising about the production of knowledge (derived from Foucault) with social relational ideas on the significance of interaction amongst groups of actors embedded in networks of relations (Bourdieu, 1992; Latour, 1999; Somers, 1994).<sup>25</sup> This approach recognises the importance of discursive practices in constituting the meanings of 'midwife' as a social/professional identity. However, it also recognises that midwives are not merely the effects of discursive formations but flesh and blood people who make day-to-day decisions about how to live their lives.<sup>26</sup>

Added to these analytic concerns are ideas derived from contemporary literature on the sociology of professions which highlight the ways in which professions utilise a variety of strategies, including claims to specialised knowledge and skill, to defend and/or justify jurisdiction or control over their work/practice vis a vis other competing professions (Abbott, 1988; Larson, 1977, 1990; Johnson, 1993, 1995; Freidson, 1986, 1994).<sup>27</sup> Rather than focussing on the organisational formalities of professions, these writers examine how occupational groups are enabled or constrained in their professionalising endeavours by contextual factors such as state policies, public/client concerns and the activities of competing professions. Of particular relevance are

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<sup>25</sup> The work of writers within the area of new economic sociology (White, 1981; Granovetter, 1985, 1990; Swedberg, 1997) who focus on the relational aspects of economic activity will also be drawn on in examining the development of various forms of autonomous midwifery practice within a quasi-market in health.

<sup>26</sup> This approach is similar to that adopted by Pringle (1998) in her study of women doctors.

<sup>27</sup> Discussion of the literature on professionalism which has most relevance to this thesis is the focus of chapter two.



approaches which focus on the contextual construction of social meanings and their implications for the organisation of work/professional practices.

Attention is therefore given to both social relations and language/texts in examining how midwives are positioning themselves as autonomous birthing practitioners in Aotearoa/New Zealand since 1990. At a more general level, this approach is influenced by writers such as Swidler (1986), Sewell (1992) and Tilly (1995, 1997) who regard culture as being "embedded" in social structure rather than being a distinct and separate phenomenon.<sup>28</sup> Culture, defined as shared understandings and their representations, is understood as being the frame within which social interaction takes place (Tilly, 1997: 5). Rather than constituting an autonomous self-driving realm, it intertwines inseparably with social relations. While discourse is regarded as a "major means of action", it neither exhausts social reality nor constitutes the sole focus of social analysis.

This relational construction of the research topic opens up for analysis and explanation categories and concepts, such as 'midwifery', 'autonomy' and 'profession', that an attributional or modernist approach closes down. It regards the meaning of these categories as being contingent, partial and historically situated rather than essentialist, ahistorical and neutral (this denies the differences and heterogeneity that exists within the phenomena). Analysis focuses on how the definitions or positionings are socially constructed in the particular institutional and historical contexts in which they are located. The task is to explain the processes which account for how things have come to be the way they are. This involves problematising or unpacking the various categories and rendering them temporally and culturally specific.

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<sup>28</sup> For a recent discussion of this debate on the relationship between culture and social structure see Crane (1994).

According to such a relational analysis, midwifery is not a fixed and given (pre-existing) entity, but a category of professional identity which is socially constructed in particular contexts. The process in and through which midwifery is socially constructed is not random, it is a political struggle.<sup>29</sup> What the category or concept 'midwifery' means at any given time, or in any given place, is contingent upon both the network of social relations in which it is embedded and the discursive practices through which it is constituted. Therefore its meaning cannot be assumed a priori but must be the focus of empirical research. By treating this category (and others associated with it) as problematic, this thesis shows how their meanings are constituted and reconstituted through processes of social interaction which take place in networks of relations that shift through time and space (Somers, 1994).<sup>30</sup>

This concern with the relational construction of midwifery recognises that the social identities of midwives (and doctors, clients and so on) are not unitary but are complexly constructed both individually and collectively. Analysis therefore focuses on how the meanings of these identities are constructed through the social relations and the discursive strategies/practices of those who are variously positioned in these groups. In analysing midwives' construction of professional identities, this thesis examines the discourses, relations and practices within various work sites that interact or combine to constitute those identities. Obviously there are differences in the representations, resources and relations available to midwives in the 1990s as compared to the 1930s, but these differences must be explained rather than assumed on the basis of the particular contexts. As historian Joan Scott said (1992: 33):

... the appearance of a new identity is not inevitable or determined, not something that was always there simply waiting to be expressed, not something that will

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<sup>29</sup> As Schudson (1980) points out, a profession is not a particular social evaluation of an occupation but a particular form of political control over work that an occupation gains.

<sup>30</sup> A useful explanation of 'interaction' is given by Tilly (1995: 41) as "the public conversation of claims, counterclaims and associated actions".

always exist in the form it was given in a particular political movement or at a particular historical moment.

This approach assumes that the form or content of midwifery's contemporary professional project is shaped by what has gone before (ie. is path dependent) but not determined by broader social and historical forces. This means that the current collection of practices and discourses which constitutes 'the' profession of midwifery in Aotearoa/New Zealand is an historic product; it is not structurally 'given' (Crane, 1994). What intentionality there is comes from the success with which various groupings of midwives, maternity consumers/representatives and policy makers have been able to articulate their interests and hegemonise their claims. As this 'success' is always likely to be partial and temporary, the struggles and activities of those associated with the profession to constitute and validate particular versions of 'midwifery' are of crucial importance.

This thesis examines the construction of particular versions of 'midwifery' in the contemporary context. One version or definition of what it means to be a midwife is determined by the state. According to this definition, a midwife is someone who has been authorised by the state to provide particular birthing services and to make financial claims on the state for their performance.<sup>31</sup> Those entitled to claim the title 'midwife', and be empowered by the state in this way, are those who have obtained the required training and have been issued with an annual practising certificate by the Nursing Council of New Zealand. This way of defining midwives highlights their relations with those associated with the central state and its health structures - hospitals and health funding authorities - whose policies influence midwives' opportunities for both independent and hospital-based practice.

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<sup>31</sup> The Nurses Amendment Act 1990 does not stipulate what type of births midwives are entitled to attend, only that they are able to assume responsibility for the care of pregnant/birthing women ie. does not state that they can only attend 'normal' births nor attempt to define what 'normal' childbirth is.

This political/legal definition of what midwives are, and what they do, competes and overlaps with a number of other definitions that arise out of midwives' relations with each other, other health professionals, their clients and consumers involved in birthing politics. Another way of positioning or locating midwives in the contemporary context is as autonomous birthing practitioners within the medical/health division of labour. Defining midwives in this way emphasises their relations with other health professionals - particularly doctors and nurses. Historically, midwifery occupied a subordinate position both within nursing, where it constituted a minority group, and in relation to medicine. However, these relations have changed considerably since midwives gained greater control over their training and practice.

The current status of midwives as a distinct professional group with autonomous status disrupts the former doctor/nurse organisation of the maternity field. This disruption has brought both tensions and opportunities for midwives, nurses, general practitioners and obstetricians as they have had to negotiate new and different relations with each other and their clients. With respect to relations between midwives and doctors, there is now considerably more variety in the form that they take. For instance, midwives who provide continuity of care, whether in a self-employed or CHE-employed capacity, are engaging in different relations with general practitioners and obstetricians than midwives who are employed to provide rostered or 'core' midwifery care in hospitals. Midwives who provide continuity of care are not only potentially in competition with general practitioners for the same clients, but some are also involved in providing shared care with them.

A third definition, or way of constituting/positioning midwives, is articulated by the NZCOM. This definition, which emphasises the relations between midwives and their clients/consumer supporters, is central to midwifery's claim to doing professionalism

'differently'. Unlike the other definitions, it is constructed by groups of midwives and maternity consumers/representatives who are concerned with constituting a distinctive professional identity for midwives. By constructing an identity based on 'partnership' with clients/consumers (as outlined earlier), midwifery is able to make particular claims over birthing work that differ from those of rival professionals. These claims, which relate to midwives' knowledge/skills and relations with women in childbirth and maternity politics, are made in an effort to consolidate professional jurisdiction or control over primary maternity care vis-a-vis doctors.

Central to midwifery's claim to autonomy - which has been articulated in the legal, state and public arenas - is a (re)conceptualisation of pregnancy and childbirth as 'normal', physiological processes. Where the medical profession interprets pregnancy and childbirth as a potentially risky or pathological process requiring supervision by those with medical training and skills, midwifery defines it as a 'normal' physiological process which has been 'medicalised' by doctors. According to midwifery's definition, the majority of pregnant/birthing women do not have obstetric complications and therefore do not need specialist medical input into their care. What they need, according to this definition, is a practitioner who not only has the knowledge and skill to facilitate 'normal' childbirth but also the legal right to organise their practice according to a different birthing philosophy.

In examining the significance of these claims, this thesis is concerned with how the meanings of concepts such as 'partnership', 'gender', 'autonomy' and 'expertise' are produced in discourses (recognised as co-existing and contested) and institutionalised in practices. As with the concepts 'midwifery' and 'profession', the task is to investigate how the meanings assigned to these categories are contested or appropriated by groups of social actors in the contemporary context ie. the historical conjunctures that make particular meanings available. This involves analysing how groups of

midwives and maternity consumers/representatives associated with the NZCOM, and state actors involved in the formation and implementation of health/maternity policy, have drawn on feminist, biomedical/scientific and New Right discourses to constitute midwifery as an autonomous form of birthing practice.<sup>32</sup>

This concern with the part that discourse plays in the constitution of professional interests/strategies is influenced by Foucault's work (1980, 1984) on the relationship between knowledge and power. Feminist theorising about the production of knowledge (eg. Pringle and Watson, 1992; Ramazanoglu, 1993; Ransom, 1993; Lupton, 1994) draws on Foucault to emphasise the importance of language and discourse in constituting aspects of social reality. Of relevance to this research is an understanding of discourses as including the social practices, and the forms of subjectivity and power relations, that inhere in various forms of knowledge.<sup>33</sup> Researching the professionalising strategies of an occupational group involves examining the ways that knowledgeability legitimates actions, which in turn legitimate the knowledge base (Fox, 1993).<sup>34</sup>

### 1.5 Entering the field

Everything becomes different, and much more difficult if, instead of taking the notion of "profession" at face value, I take seriously the work of *aggregation* and symbolic imposition that was necessary to produce it, and if I treat it as a field, that is, as a structured space of social forces and struggles (Bourdieu, 1992: 243).

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<sup>32</sup> See Rushing (1993) for discussion of how two particular ideologies, science and feminism, have been used by midwives and their consumer supporters in their struggles to legitimate midwifery in the health care systems of Canada and the United States.

<sup>33</sup> Literature from the sociology of professions (Larson, 1990; Chua and Clegg, 1990; Witz, 1994; Brain, 1994) which draws on the work of Foucault to examine the production of knowledge as a constitutive component of professional control is discussed in chapter two.

<sup>34</sup> Efforts to develop midwifery's knowledge base following the introduction of direct entry midwifery (DEM) training are discussed in chapter four.

Embarking on this research project did not mark my first entry into the maternity field in Aotearoa/New Zealand. Pregnant with my first child in Auckland in 1983, I became aware of how few choices there were in terms of the care available. As there were no general practitioners in our area that offered maternity care, and I had no desire to have a homebirth, I approached an obstetrician whose practice had been recommended. Because he was a full-time consultant at the base maternity hospital, my appointments were scheduled to coincide with his rostered duty in the antenatal clinic. Unlike other women going through the clinic system, I had the assurance of receiving care from the same doctor at each antenatal check and knowing that he would be at the birth.

It was a Sunday afternoon in mid-May when our first daughter came into the world. My partner/husband and I went into the hospital early that day for me to be induced. I was full-term, and close to the onset of labour, but there was some concern about how small the baby was. My progress throughout the morning was monitored by labour ward midwives who called the specialist back in just before the birth. I chose to stay in one of the hospital's birthing rooms, rather than be transferred to the more sterile delivery suite, and used gas (nitrous oxide) just to get through the most painful stages. Aside from being kick-started with prostaglandins, the birth was straight forward and required no further interventions.

The week following the birth was spent adjusting to motherhood and the daily routines in a busy postnatal ward. I remember feeling trapped in what seemed like a strange and airless environment in which there was no escaping crying babies who constantly needed feeding, changing or comforting. As the new mother of a "small for term" baby, I suddenly had the responsibility of ensuring that my daughter gained the required weight. Conflicting advice from midwives and nurse aides who came and went with every change of shifts did not make my task any easier. Suggestions that she should be given a bottle of milk formula - to make sure that she got the necessary

quantity of food - were not helpful for someone who was trying to master the rather tricky art of breastfeeding.

Fortunately, I had this skill well and truly mastered by the birth of our second daughter in 1985. My pregnancy and birthing care was similar second time around except that the obstetrician moved into private practice a month or so before the birth. This meant that my antenatal checks took place in more attractive and comfortable surroundings - and there was an account at the end for his services. Again I chose to give birth at the base maternity hospital - in one of the increasingly more 'homelike' birthing rooms - with the assistance of midwives on duty in labour ward (one of whom happened to be on duty during my first birth). While giving birth was just as hard second time around, the postnatal experience was definitely easier.

Apart from having been positioned as a consumer of maternity services, I have also been the support person at five hospital births. These births have taken place since August 1990 and the introduction of legal autonomy for midwives. The first two births (in 1990 and 1994) were those of my sister in Auckland. Due to various complications before and during the pregnancies, her care was provided by a private obstetrician. He made it clear that he did not support her engaging the services of an independent midwife (hence my involvement despite having moved to Christchurch). The third birth, which was also in 1994 but in Christchurch, was also an 'abnormal' case requiring an obstetrician and eventually a caesarean section. The final two births were those of another Christchurch friend who chose shared care between a general practitioner and independent midwife (in 1995) and then a midwife-only birth (in 1998).<sup>35</sup>

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<sup>35</sup> An account of my involvement as a support person at these births appears in chapter six.



Participating in these births gave me an opportunity to observe the interaction between some practitioners belonging to key professional groups within the maternity field; to see how they related to each other and the pregnant woman (and her supporters) through labour and birth. As a support person, I also had an opportunity to chat on an informal basis to a variety of practitioners about issues associated with midwives being able to practice independently and the introduction of a fixed-fee system of funding maternity services. Where appropriate I disclosed my research interest in these issues. After one of the births that involved an obstetrician I followed up our fleeting introduction with a request for an interview - which he was happy to give.

My entry into the maternity field as a postgraduate student/researcher began in 1992 when I conducted a number of interviews with midwives, doctors (several general practitioners and an obstetrician) and maternity consumers for the pilot phase of proposed research on the introduction of 'domino' midwifery in Christchurch.<sup>36</sup> These interviews highlighted the complexity and heterogeneity of relations both within and between the key professional groups in the maternity field. My report noted the need to be aware of philosophical, political and practical differences that existed between various groups of midwives which contributed to tensions within the evolving profession of midwifery as well as between midwifery and groups within the medical profession.

Gathering interview and documentary material that enabled me to examine how midwifery was doing professionalism 'differently', both within its ranks and vis a vis other professions, became a major focus of my research as a doctoral student. As discussed in the previous section, my research interest lay in examining how midwives have strategically deployed particular constructions of gender and expertise/authority in

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<sup>36</sup> 'Domino' stands for *domiciliary* midwives *in* and *out* of hospital. The term refers to a form of midwifery practice in which midwives provide antenatal and postnatal care in a client's home and assist with her birth in a hospital (as discussed in chapter six).

challenging doctors' legal jurisdiction over childbirth and staking their own claims over the work. This approach recognises the agency of midwives as central to the construction of midwifery as a form of professional practice. As agents (individual and collective) of social interaction, they do not simply follow rules but are strategists who have the potential either to reproduce existing structures or to bring about shifts (Bourdieu, 1992).

Recognising midwives (and doctors, state actors and so on) as actors or agents who know what they are doing puts the onus on the social researcher to not only learn from them what they are doing but also how and why they are doing it (Latour, 1999). Research strategies therefore aim at learning from various groups of actors in the particular field under study their understandings of their interests, resources and reasons for action. Bourdieu highlights (1992:107) the need to focus on actors' knowledge of the field in which they are located and in which they can produce effects.

And it is knowledge of the field itself in which they evolve that allows us best to grasp the roots of their singularity, their *point of view* or position (in a field) from which their particular vision of the world (and of the field itself) is constructed.

To understand the process by which midwives were positioning themselves as independent birthing practitioners in the maternity field involved investigating sites (national and local) where claims re autonomous midwifery were being made and new forms of practice were being developed. I was concerned with examining not only how midwives were variously positioned (relationally and discursively) vis a vis birthing women, maternity consumer representatives, other health professionals, state actors and so on, but also how these positionings were challenged or reworked by midwives and others. A key question I sought to answer was: in crafting themselves in this way/being crafted by others in this way, what are the distinctive skills, forms of

professional relations and understandings/discourses about birth and their positioning in the health/maternity field that midwives variously develop?

To answer this and other key questions, I conducted approximately 50 interviews with variously positioned actors in the maternity field (mainly in Christchurch but also in Timaru, Dunedin and Auckland) and analysed local and national documentary material. The research participants were selected, or recommended by others via a 'snowballing' process, on the basis of their location within the maternity/health field.<sup>37</sup> They included NZCOM leaders, midwifery educators, self-employed ('independent') and CHE/hospital-employed practitioners, direct entry midwifery students, CHE/hospital obstetrics managers, general practitioners, obstetricians and maternity consumer representatives. Most interviews took between one and two hours and were taped and transcribed. The transcripts were returned to participants for comment or correction.

Documentary sources included submissions to various government/select committees on maternity related issues from professional organisations including the NZCOM, the New Zealand Medical Association (NZMA), the Royal New Zealand College of General Practitioners (RNZCGP), the Royal New Zealand College of Obstetricians and Gynaecologists (RNZCOG), the New Zealand Nurses' Organisation (NZNO) and the Nursing Council of New Zealand. Also examined were submissions from groups representing maternity consumers such as the Home Birth Associations (HBA), La Leche League and Parents Centre. Other documentary sources included Health Department and Regional Health Authority (RHA) reports; professional journals, newspapers and newsletters; recorded radio interviews; conference proceedings; newspaper and magazine articles and unpublished theses.

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<sup>37</sup> More detailed discussion of participant selection is provided in the methodological appendix. Also included in the appendix is a copy of the consent form that was given to research participants who were not spokespeople for an organisation and who were therefore assured of anonymity and confidentiality.

Basing the study in Christchurch had advantages in terms of logistics and empirical opportunities. Most importantly, it provided easier access to the national director of the NZCOM, Karen Guilliland, who has been a key actor in the maternity field over the last decade. As the inaugural president of the college, and then its national co-ordinator, Guilliland has played a major role in shaping developments in maternity services generally, and midwifery in particular. Her involvement in this project, through numerous interviews and informal discussions, provided valuable information on political and professional issues. This interview material plus documentation accessed through the Midwifery Resource Centre, which was set up by the college to provide midwives and maternity consumers with information on childbirth and maternity services, provided much of the empirical data analysed in the thesis.

Another advantage of basing the research in Christchurch related to developments in forms of independent midwifery practice. As a city/region in which a high proportion of midwives chose to not only become self-employed, but also provide predominantly midwife-only care, it provided opportunities for researching how the 'ideal' model of independent midwifery was being put into practice. Attendance at several regional college meetings, and interviews with self-employed midwives working in different practice arrangements, alerted me to a variety of issues facing independent practitioners. As Christchurch was the first place in Aotearoa/New Zealand to have a midwife-owned and operated birthing centre, it also offered an opportunity to gather interview and documentary material on this midwifery initiative.

While Christchurch was at the forefront of the move into independent practice, it was not a key site for developments in relation to Maori and Pacific Islands' midwifery services. These tended to be in the North Island, especially Auckland, where there was a strong demand for culturally appropriate maternity services. An example of such a development was the opening of a maternity centre staffed by Maori and Pacific Islands

midwives in South Auckland in 1996. This centre offered Maori-focused antenatal education and independent midwifery services (Abel, 1997: 260). My decision not to research Maori and Pacific Islands' maternity initiatives was made on the basis of my ethnicity as well as my geographic location. I did not consider it appropriate for me, as a Pakeha/Tauwi researcher based in Christchurch, to be examining such initiatives, especially in their formative stages.

Research for the thesis was carried out between 1993 and 1998. Information gathered between 1993 and 1995 related mainly to how midwifery autonomy was being negotiated, at both a national and a local level, in a context of public/health sector restructuring. Interviews with college representatives and practitioners focussed on the implications of on-going changes in the funding and provision of primary health and maternity services for various forms of midwifery and medical/maternity practice. Of particular interest, was how differently positioned groups of midwifery and medical practitioners were seeking to consolidate their professional claim over the provision of 'normal' or primary maternity care through the new sets of relations and practices in which they were embedded. Also of interest were developments in midwifery training, including the introduction of direct entry degree/diploma programmes at several polytechnics.

Fieldwork for this project continued on into 1998 due to the introduction of a major change in the funding of maternity services in mid-1996. After decades of paying for primary maternity services on a fee-for-service basis, the Government (through the RHAs) introduced a fee-per-case, modular payment system. A central concern in this thesis relates to the significance of state activity, particularly in relation to the specifics of funding arrangements, in terms of the opportunities available to midwifery and medicine to either defend and/or extend their jurisdiction over the provision of maternity services. Therefore, it was important to gather empirical material on the consequences,

intended and otherwise, of such a major policy change. This enabled analysis of a significant development within the primary maternity field - the setting up of continuity/caseload midwifery schemes in some public and private hospitals.

## **1.6 Mapping the thesis**

The central focus of this thesis is how midwives in Aotearoa/New Zealand have been 'doing' professionalism since (re)gaining the legal right to practise independently of doctors in 1990. This involves examining how an alternative view of pregnancy/childbirth as a 'normal' physiological process, most appropriately managed by those with 'expertise' in midwifery, has been developed and institutionalised and turned eventually - not just through knowledge claims - into jurisdiction. The thesis is divided into three parts. Part one, which consists of the first two chapters, provides an introduction to the case study and the theoretical agendas of the thesis.

Part two, which incorporates chapters three to five, examines how midwifery autonomy (ie. professional power) has been negotiated at the level of policy and organisational structure. The focus in these chapters is on interaction between the various professional organisations in the maternity field and groups of state actors. This focus is particularly evident in chapters three and five which examine changes in government policy regarding the funding and provision of health/maternity services, both historically and in the contemporary context, and the implications of these changes for patterns of professional control amongst doctors and midwives. Discussion in both these chapters supports the argument that the 'success' that professional groups have in advancing their interests at any given time depends on these interests being linked to broader social and economic objectives of state actors.

Chapter four looks at the implications of a national policy change to another important aspect of professional activity, the training of new practitioners. With the introduction of direct entry midwifery (DEM) training, midwifery had the opportunity to begin formalising a knowledge base which underpins its claims to autonomous status. Producing midwives with an understanding of childbirth as a 'normal' physiological process, and of themselves as independent practitioners who provide continuity of care to their pregnant/birthing clients, was crucial to midwifery consolidating its autonomous status vis a vis both nursing and medicine.

Part three of the thesis shifts the focus to how midwifery autonomy/independence has been negotiated at the level of everyday practice. Chapters six, seven and eight examine various forms of maternity practice, involving both competitive and collaborative relations between midwives and doctors, that have developed as a consequence of midwifery autonomy and the creation of a quasi-market in health services. These chapters highlight the importance of investigating the jurisdictional manoeuvrings of professional actors/practitioners at the local level to appreciate the diversity of responses to opportunities and constraints that emerge as an outcome of decisions made at a national level.

Chapter six focuses on different forms of 'independent' midwifery practice that developed out of new relations between midwives, general practitioners and obstetricians in the competitive maternity market. Through these new forms of practice, which were organised in and across a variety of sites and around various claims to expertise, practitioners sought to secure a clientele for their services. The chapter argues that their capacity to do this was influenced by the material and discursive resources and sets of relations that they had to draw on from their particular location within the market. This location is contingent on a variety of factors including funding arrangements. The shift to a modular, fixed-fee payment system contributed to many

general practitioners exiting the primary maternity service thereby enabling midwifery to enhance its jurisdiction.

Concern with the consequences of this new funding arrangement for how midwifery is organised in hospitals/CHEs is the focus of chapter seven. This chapter argues that the introduction of a competitive model of contracting into the primary maternity sector gave some hospitals both an opportunity and a financial incentive to reorganise their midwifery services so as to compete with independent contractors for a share of the market. In analysing the introduction of continuity or caseload midwifery at two very different hospital/CHE sites, it shows how this new form of professional practice could be developed at the intersection of specific funding regimes and particular institutional arrangements.

Attention to the connection between funding arrangements, institutional locations and new forms of professional practice is continued in chapter eight. It focuses on the development of midwifery services by two providers who entered the market for publicly-funded primary maternity care in Christchurch as a consequence of new contracting opportunities. In both of the sites investigated, different forms of midwifery practice were organised around giving clients access to birthing and postnatal facilities which differed from those in the public health system. Like the public/independent providers, these organisations utilised the material and discursive resources at their disposal to make their services as attractive as possible to both funders and clients.

Chapter nine draws this particular account of midwifery professionalism in Aotearoa/New Zealand in the 1990s to a close. It provides a summary of the key themes and arguments developed throughout the thesis and an indication of some directions for future research.



## Chapter Two

### Gendering the politics of expertise

Flexibility seems to be a more fundamental criterion of professionalism than any set of properties that might be invented. Professionals exist in the form in which society - market or state - finds use for their knowledge base (Torstendahl, 1990: 10).

#### 2.1 Introduction

This chapter provides an expanded introduction to the theoretical agendas of the thesis by locating the professional project of midwives in contemporary Aotearoa/New Zealand within debates primarily in the literature on the sociology of professions. As indicated in chapter one, this research addresses a number of important themes within this literature. The intention, however, is not to provide a comprehensive review of the literature related to professions, but a discussion of the debates which provide an analytic 'springboard' for the thesis. Like Halford et al (1997:1), I take the view that theoretical elaboration takes place alongside, rather than before, social research. The arguments/themes outlined in this chapter were considered and clarified through the empirical research rather than simply being illustrated by it.

Midwifery's status as an independent or autonomous profession post 1990 is not simply a reflection of midwives' skills, expertise or ethical standards or the 'successfulness' of professional strategising. Rather, this status is the outcome of interaction between key groups of actors in the maternity/health care field. Whatever current autonomy or control that midwifery has over childbirth and the provision of primary maternity services is a contingent outcome of a particular configuration of relationships within this field. The analytic focus of this thesis is therefore on

examining the link between these social/professional relations, the organisational practices associated with them and the discourses or claims that underpin them. Literature on the sociology of professions is used to frame the particulars of relational professionalism at a specific time in the context of Aotearoa/New Zealand.

Central to this argument are a number of assumptions or understandings about how professions manage to negotiate and maintain their advantaged position in the division of labour. Some of these assumptions derive from mainstream (malestream) writing about the professions (dating from the 1970s) while others relate to more contemporary theorising, influenced by Foucault (1978, 1980, 1981) on the relationship between knowledge and power. Of particular relevance are understandings about the complex, dynamic and contested nature of professional autonomy/control. This research assumes that the jurisdiction that a profession has over a particular area of 'expert' work is the outcome of a competitive political process involving a complex combination of occupational strategies, state policies and shifts/changes in public understandings about what constitutes 'expertise'.

In tracing key shifts in the sociological debates about professions and professional control, it is important to recognise that there are important continuities between some of these arguments with respect to their assumptions. Whilst there is a tendency to discuss the arguments as though they emerge in some sort of chronological order, they do not constitute a linear progression of ideas. Aspects of the debates overlap and interrelate. However, there is a discernible 'storyline' in this account of how professions have been theorised. This involves a shift from seeing them as occupational groups with individual unfolding careers (eg. Wilensky, 1964) to occupational groups that compete and/or collaborate with other groups in historically and culturally specific contexts for jurisdiction or control over areas of work (Abbott, 1988).

Central to this shift in theorising professions has been changing understandings about the nature and role of a profession's knowledge base. Broadly speaking, this has involved a shift from seeing the knowledge base as an attribute or characteristic that a profession possesses (Greenwood, 1957; Goode, 1957; Etzioni, 1969) to seeing it as providing ideological cover in the struggle for power and status (Freidson, 1970a, 1970b, 1983, 1986; Larson, 1977; Johnson, 1972, 1982). A more contemporary shift has been to analyse a profession's knowledge base as a highly variable and contingent outcome of the complex interactions that take place between professions, state actors, clients/consumers and so on (Abbott, 1988; Larson, 1990; Brain, 1994). The emphasis in this latter approach is on the embedding of knowledge in various organisational and/or professional forms.

The importance of the relational construction of professional knowledge is highlighted in discussion of the adoption of a 'partnership' model of practice by midwives and maternity consumers associated with the NZCOM. Analysis of how midwifery has been constituted as a form of feminist professional practice based on 'partnership' shows how particular constructions of gender and expertise can be used as discursive resources in the struggle over autonomy. Doing professionalism according to this 'new' model of practice involves positioning midwives as 'experts' vis a vis other health professionals but as co-contributors of knowledge with maternity consumers. An argument is made in this chapter that a distinction between 'old' and 'new' forms of professionalism is a false dichotomy. While 'new' professionalism may provide the basis for more equitable professional/client relations, it also supports an alternative claim to 'expertise' and autonomy.

## 2.2 Debates about professions

Early sociological theorising on the professions distinguished them from lesser occupations by a set of central attributes. Functionalist theorists (Carr-Saunders and Wilson, 1933; Greenwood, 1957; Goode, 1957; Etzioni, 1969) identified the professions' attributes as high levels of skill based on theoretical knowledge, altruistic ideals of service and adherence to a code of conduct maintaining integrity. Functionalists assumed that these attributes were structurally given and non-ideological. They were seen as social facts rather than as claims and as being in the mutual interest of professionals and clients rather than as self-serving.<sup>1</sup> Some functionalists (eg. Wilensky, 1964) also assumed a 'natural history' of professionalism based on a determinate series of stages through which every occupation undergoing professionalisation must pass.

A more critical stance on the professions was taken by symbolic interactionists who focussed on the actions and interactions of individuals and groups. Writers such as Hughes (1958, 1971) and Becker (1961) examined professionalism as a form of social practice. In a classic article Becker (1962:33) suggested that the term 'profession' was not a neutral and scientific concept but a "folk concept, a part of the apparatus of the society we study, to be studied by noting how it is used, what role it plays in the operations of that society".<sup>2</sup> The detailed ethnographic studies conducted by these Chicago School sociologists raised questions about a concept of professionalism based

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<sup>1</sup> It is important to recognise the 'value' of Talcott Parsons' concern with expertise as an asymmetric social relation between a professional and a client. Dingwall acknowledges that the complexity of Parsons' work on professions has been obscured in an overall lambasting of functionalism. See Dingwall and Lewis (1983: 1). In focussing on the dyadic relation between professional and client, Parsons and other functionalists asked how such a social relationship had to be structured for healing (or some other individual professional act) to occur (ie. professionalism as a means to control a difficult social relation).

<sup>2</sup> The term 'folk' concept or category was also used by Freidson (1986: 35-36).

on shared cultural norms and expertise and presented it as the outcome of skirmishes over resources, task territories and social status (Chua and Clegg, 1990).

While the symbolic interactionists were critical of the trait and functionalist assumptions about the professions, their work has been criticised for not addressing the influence on professions and professional practice of wider structures of power and on-going historical processes. According to Saks (1983: 5), for example, these writers did not examine what a claim for professional status entailed in terms of broader privileges, nor did they begin to explore the structural conditions under which particular groups were liable to be successful in their claim to be a 'profession'. He identified another weakness of their analysis as being that it characteristically dealt with individual practitioners rather than the more significant institutional features of professions.<sup>3</sup> Out of this interactionist tradition came one version of a more critical 'power' approach which dominated sociological writing on the professions in the later 1960s and 1970s (Hall, 1983: 11).

This version of the 'power paradigm', which became an important model for the sociology of the professions in the United States, was developed by Eliot Freidson (1970a, 1970b, 1973, 1983, 1986, 1994). Like other American writers, Freidson was concerned with identifying the defining characteristics of the professions (Macdonald and Ritzer: 1988). Taking an institutional/structural approach, he regarded professions as a phenomenon of labour market organisation.<sup>4</sup> His books *Profession of Medicine* (1970a) and *Professional Dominance* (1970b) emphasised the ideological character of professional claims, unjustified aspects of professional privilege, and the way

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<sup>3</sup> Despite these criticisms, symbolic interactionists such as Bucher and Strauss (1961) and Becker (1961) are recognised as forerunners to the contemporary culturalist approaches to analysing professions with their emphasis on situational flexibility and self-creation of identities. See Collins (1990: 13).

<sup>4</sup> For discussions of Freidson's contribution to the sociology of professions see Brint (1993), Halpern and Anspach (1993) and Coburn (1992).

organised professional institutions create and sustain authority over clients and associated occupations.<sup>5</sup>

Freidson analysed professions as occupations that exercised the capacity to create exclusive shelters in the labour market for practitioners through the monopolisation of educational training and credentials required for the attainment of economic opportunities in the market. He saw their essential characteristic as being the link they secured between tasks (for which a demonstrable market demand existed), advanced training and privileged access to the market.

Professions (are) those occupations that have in common credentials testifying to some degree of higher education and that are prerequisites for holding jobs. Higher education presupposes exposure to a body of formal knowledge, a professional 'discipline' (Freidson, 1986: xii).

Freidson identified the control over work, or technical autonomy, as the most fundamental and widespread power of professionals. This autonomy, he argued, was only technical and not absolute. It depended on the power of the state and the influence of elite sponsors. The privileged position of a profession was therefore "secured by the political and economic influence of the elite which sponsors it" (1986: 24). Freidson regarded the cognitive and normative features of professions, which the earlier theorists had viewed as stable and fixed characteristics, as providing the basis of arguments to establish the boundaries of their domains and the membership who belong within them.

Another version of the 'power' approach, which reflected neo-Marxist rather than neo-Weberian concerns, was developed in Britain by Terence Johnson (1972, 1982). Like

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<sup>5</sup> Freidson contributed to work on the professions during the "revisionist wave" (Collins, 1990:13). According to Schudson (1980), the revisionist definition of 'profession' holds that it is not possible to distinguish professions by the nature of their work or training. What is distinctive about them is nothing intrinsic to the work of professionals but is simply the status-honour they somehow accrue. A profession, according to this definition, is any occupation which any society regards as a profession.

Freidson, Johnson understood profession as a means of controlling work. He saw professionalization not as a process of upgrading the essential character of a kind of work but rather a political process of gaining greater control over work. Like other British theorists, Johnson was concerned with the place of the professions in the larger social structure; with the links between the professions and the stratification system (Macdonald and Ritzer, 1988: 254). His analysis focussed on the relations between producer and consumer of professional services and the extent to which the producer could or could not control the relationship and thereby benefit from it.

In contrast to Freidson, Johnson focused on the relationship between the professions and the state. He argued that the development of professional occupations could be seen in terms of the opposition between state intervention and professional autonomy. Indicative of his explicitly neo-Marxist approach was his argument that "the transition to capitalism in England was not marked by a separation of economic and political institutions, but by an historically unique articulation which involved the interrelated processes of state formation and professionalisation" (1982: 188). In Johnson's view, the relationship of the state to professions presented itself as one of constant struggle and seeming hostility while at the same time constituting an interdependent structure.

Other British writers (Parry and Parry, 1976; Parkin, 1979; Murphy, 1984; Macdonald, 1984, 1985) who contributed to this debate about the relationship between professions and the state, and the position of professions in the class structure, drew on Weberian ideas about the importance of credentialism and closure for securing a privileged social position. These writers shared a concern with professionalism as an occupational strategy to control the market for particular services. Drawing on Weber's concept of social closure, they analysed professions as legally privileged groups which

had managed to monopolise to a considerable degree social and economic opportunities (Saks, 1983).<sup>6</sup>

While it was primarily British writers who drew on Marxist and Weberian theories to analyse professions (Macdonald and Ritzer, 1988), a notable exception is the American theorist Magali Sarfatti Larson (1977). Building on the work of Freidson, Larson was concerned with how particular groups of people attempt to negotiate the boundaries of an area in the social division of labour and establish their control over it (1977: xii). While Freidson recognised that such groups had to gain support from strategic social or political groups, his analysis did not take account of the concrete historical conditions in which groups of specialists had attempted to establish a monopoly over specific areas of the division of labour. Larson, on the other hand, showed how the type of society and class structure was crucial to the emergence of professional groups.

Larson identified two aspects of modernity as being of significance to the formation of professions - scientific knowledge and the existence of free markets. She drew on Weber's ideas on social stratification and the importance of qualifications and expertise, ie. specialist knowledge, as providing "opportunities for income" in a market society.<sup>7</sup> Larson explained (1977: xvii) her approach:

Professionalization is thus an attempt to translate one order of scarce resources - special knowledge and skills - into another - social and economic rewards. To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in a system of stratification. The focus on the constitution of professional markets leads to comparing different professions in terms of the 'marketability' of their specific cognitive resources.<sup>8</sup>

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<sup>6</sup> The work of contemporary neo-Weberian writers (Witz, 1992; Chua and Clegg, 1990) will be discussed further on in the chapter.

<sup>7</sup> The theoretical base for Larson's arguments in *The Rise of Professionalism* (1977) shifts with the emphasis becoming more neo-Marxian in the later chapters. This is why she is identified as both neo-Weberian and neo-Marxist.

<sup>8</sup> In a later article (1990: 30), Larson claims that professionalization "results in translating one order of scarce resources (expertise created through standardized training and testing



According to Larson, the market control aspect of the 'professional project' required that there should be a body of relatively abstract knowledge, susceptible of practical application, and a market, or potential market, for the occupational group's services (1977: 66).<sup>9</sup> She identified the core of the professional project as being the establishment of a link between education and occupation; between *knowledge* in the form of cognitive exclusiveness and *power* in the form of a market monopoly.<sup>10</sup> This link was secured through university qualifications. In order to create a professional market and negotiate cognitive exclusiveness, occupations had to produce a distinctive commodity/service (which had to be standardised), produce its practitioners ("the producers") and secure state sponsorship.

Larson's approach focused attention on the contribution of a particular cognitive base to the successful professional project. Her emphasis, like that of Freidson, was on how knowledge was used as a resource in the struggle for power and status; how it was constructed and advanced by occupations (and segments within them) in a process aimed at collective upward social mobility through social closure and monopolization.<sup>11</sup> For Larson, as Willis noted (1993: 104), this process had an ideological component. What professions had in common was an occupational ideology staking a claim to autonomy in the performance of their work and in regulating their affairs.

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at the higher levels of the formal education system) into another (market opportunities, work privileges, social status or bureaucratic rank)". The emphasis here seems to be on the issue of scarcity rather than that of monopoly.

<sup>9</sup> Larson has been described as a 'monopolist' because of the Weberian argument she pursues about occupations striving for monopoly in the market for services and for status in the social order. These dual objectives can be seen as manifestations of an underlying strategy of social closure, whereby 'ineligibles' are excluded from the group and denied access to its knowledge, its market and its status.

<sup>10</sup> Discussion of Larson's later work, which draws on Foucault's ideas about knowledge and power to look at the production of 'learned' or 'knowledgeable' discourse and its implications for the professional phenomena, appears further on in this chapter.

<sup>11</sup> Brante (1990: 76) describes this as "the cynical perspective" (as opposed to the earlier "naïve perspective") because professions are seen as instruments or resources by which their members can gain higher income, power and prestige - "a kind of collective egoism".

Professionalism was therefore both a material practice and a set of ideas that justified that practice.

Larson's concept of a 'professional project' is used in this case study/thesis to highlight the fact that midwifery in Aotearoa/New Zealand is not simply a social fact or a given, but an entity whose members have to work at bringing into existence and who then have to keep up a continual effort to maintain and, if possible, enhance the position of.<sup>12</sup> Emphasis in this term is on the "coherence and consistence" of collective actors' intentions and actions, even though "the goals and strategies pursued by a given group are not entirely clear or deliberate for all the members" (Larson, 1977: 6). It is therefore consistent with an approach that recognises that the struggles and activities of those associated with a profession to constitute and validate particular versions of 'expertise' are of crucial importance.<sup>13</sup>

Larson and Freidson's focus on the cognitive and normative features of professions being used as the basis of arguments to establish their boundaries, and the membership who belong within them, is a useful starting point for analysing how midwifery is constituted as an autonomous profession through the claims made by various groups of actors as to midwives' knowledge and expertise. This approach puts the analytic focus on the claims that midwifery makes about itself, the fact that society acknowledges the claims, and the consequent higher positioning in the status ordering of occupational groups that midwifery has attained in a particular national context (especially vis a vis nursing and other female-dominated occupations in the health care division of labour).

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<sup>12</sup> Witz (1992: 5) also uses the term 'professional project' to "establish the concrete and historically bounded character of profession".

<sup>13</sup> It is important to recognise that the concept 'professional project' represents an 'ideal type' (Weber, 1978) and that the particulars of any case are a matter of empirical investigation.

Both writers also draw attention to the link between higher education, ie. training in a body of abstract or formal knowledge, the obtaining of credentials and opportunities for social and economic rewards. Larson identified the production of a distinctive commodity or service and the training of practitioners as preceding the securing of state sponsorship. This thesis challenges assumptions about such an ordering of the professionalising process in that it was state support for legal autonomy that enabled midwifery leaders and educators to begin developing and standardising a distinctive midwifery service (see chapter four). This service was based on practitioners having knowledge and skills - in managing childbirth as a 'normal' physiological process - that were not a feature of previous midwifery/obstetric nursing training.

Another aspect of Larson's work with which this project takes issue is the limited range of outcomes of professional struggles. Like other theorists using a neo-Weberian closure model, Larson assumes that professions are endeavouring to secure a monopoly of expertise in the market and status in a system of stratification ie. a common career pattern. This does not allow for the dynamics of interactions among professions, and between professions and the state, which produce a variety of outcomes or settlements. This thesis shows how, in the context of a quasi market in health services, there can be advantages for both the state and the professions in having overlapping jurisdiction over the provision of primary maternity services. This can enable some practitioners to engage in collaborative, interprofessional relations that enhance their capacity to practice independently (for a more useful approach to analysing relations among professions in a particular field see Abbott (1988) below).

### **2.3 Professions in Decline?**

Since the early 1970s the primary target of most of the British and American writers criticising the professions was medicine. Writers such as Freidson (1970a, 1970b),

McKinlay (1973) and Berlant (1975) looked at how medicine dominated social policy, the other occupations in the health-care division of labour, the institutions in which its members worked, patients or consumers and how it had "medicalised" social or personal problems.<sup>14</sup> Freidson had identified (1970b: 136) medicine as the only occupation that was "truly autonomous" within the health care industry because it had the authority to direct and evaluate the work of others without being subjected to any formal direction or evaluation by them.<sup>15</sup>

By the late 1970s this emphasis on the power of medicine, and other dominant professions, began to shift. Influenced by neo-Marxist thinking, the literature turned to predicting the decline of medicine, law and professions in general.<sup>16</sup> In advancing an argument about deprofessionalisation, Haug (1973, 1975, 1976, 1988) and Haug and Lavin (1981, 1983) claimed that the medical profession had been losing its prestigious societal position and the trust that went with it. This, she/they argued, was due to the erosion of medicine's monopoly over access to its defined body of knowledge coupled with marked increases in educational attainment which made the public less likely to view medical knowledge as mysterious. Another factor was the increasing specialisation within medicine which made doctors more dependent on the expertise not only of other doctors but also of non-physicians (Wolinsky, 1993).

Haug also identified the growth of self-help consumer groups, together with the emergence of allied health care workers, as further reasons why the medical profession

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<sup>14</sup> The professional dominance perspective, developed by Freidson, differentiated between dominant professions (those that had achieved autonomy and therefore stood in an entirely different structural relationship to the division of labour) and subordinate professions.

<sup>15</sup> See Willis (1983, 1989) for a discussion of medical dominance in the Australian context.

<sup>16</sup> Freidson does not agree with claims that professionalism is in decline, arguing instead that it is taking a new form. He describes (1994: 9) professionalism as being "reborn" in a hierarchical form in which everyday practitioners become subject to the control of professional elites who continue to exercise the considerable technical, administrative and cultural authority that professions have had in the past. This argument is known as the "restratification thesis" because of the emphasis on internal stratification/differentiation as enabling a profession to maintain control/autonomy over work.

was losing its position. She regarded this development as increasing reliance on lay, or at least the nonprofessional, referral systems. These claims are similar to those made by contemporary writers (Stacey, 1992; Davies, 1995; Williams, 1993) who argue that 'old style' professionalism has had its day. These arguments, which are discussed later in this chapter, support calls for a 'new' form of professionalism in which recognition is given to the knowledge and experience of the client as well as the professional.

Neo-Marxist writers (Oppenheimer, 1973; McKinlay, 1973; Derber, 1982; McKinlay and Arches, 1985; McKinlay and Stoeckle, 1988) argued the possibility of the 'proletarianization' of the professions and the reduction in their class advantages as a consequence of increasing bureaucratisation. McKinlay, for example, argued that the growing corporatisation and bureaucratisation of medicine had resulted in eliminating the self-employment and autonomy of doctors (Wolinsky, 1993). He regarded physicians as becoming more like other labourers as the number and extent of intermediaries between doctors and patients increased. The bureaucratisation of the medical workplace also meant that physicians were, like other salaried employees, increasingly subject to rules and other hierarchical structures not of their own making.

A problem with these arguments is that they assume that professions are heading in a particular 'direction' and therefore accept, albeit implicitly, the attribute model of professionalism. Change is interpreted as professionally damaging.<sup>17</sup> They also operate with a zero-sum conception of power which assumes that increases in market or state power equal decreases in the power of professions. This thesis demonstrates the value of focussing, not only on structural and policy issues (part two), but also on the everyday experiences of practitioners at work (part three). Analysis of the complex

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<sup>17</sup> See Roach Anleu (1992) and Rothman (1984) for discussions of whether changes in the status of the legal profession constitute diminished professional control (ie. deprofessionalisation) or new forms of organisation. See Elston (1991) for a similar discussion of challenges faced by the medical profession in Britain and Lupton (1997b) for analysis of the professional position of doctors in Australia.

relations that have developed between groups of midwives and doctors since 1990 highlights the inappropriateness of a simplistic distinction between dominant and subordinate groups. Assumptions about midwives and/or doctors possessing more or less power are not as constructive as an understanding of power (influenced by Foucault) as shared, negotiated, relational, situational and a resource for action.

## 2.4 The 'system of professions'

In stark contrast to arguments that cast doubt on the relevance of professions as a form of social organisation is the approach to analysing professional activity advanced by Abbott in *The System of Professions* (1988). Using an interactionist/ecology approach, Abbott identified professionalism as a system of competitive occupational relations centring on jurisdictional claims and disputes.<sup>18</sup> Writing in response to what he described as the 'monopoly' approach of Larson (and Berlant, 1975; Johnson, 1972), Abbott argued (1988: 2) that "a fundamental fact of professional life (is) interprofessional competition ... It is the history of jurisdictional disputes that is the real, the determining history of professions". In focusing on the content of professional work, he argued that the central phenomenon of professional life is the link between a profession and its work; a link he called "jurisdiction".

To analyse professional development is to analyse how this link is created in work, how it is anchored in formal and informal social structure and how the interplay of jurisdictional links between the professions determines the history of the individual professions themselves (Abbott, 1988: 20).

Rather than building explanations of professions around fixed sequences or "common career patterns" (the organisational aspects), Abbott highlighted the work that an occupational group actually does in relation to other occupational groups. His concern

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<sup>18</sup> See Dingwall and King (1995) for a discussion of Herbert Spencer's influence on the "ecological" perspective of sociologists in the Chicago tradition such as Abbott.

was to account for the dynamics of interactions among professions and the resulting changes in what he called the "system" of professions. Central to developments in this interdependent system were competitive struggles for jurisdiction; the conditions and consequences of 'claims of jurisdiction' over existing, emergent and vacant areas of expertise. As Johnson (1989: 412) noted, professionalism for Abbott was merely one possible outcome of such competition rather than a generalised societal trend. His model allowed for multiple forms of accommodation or settlement of contending jurisdictional claims (Abbott, 1988: 69-70).<sup>19</sup>

In focusing on the link between a profession and its work, Abbott highlighted the importance of theoretical or abstract knowledge.<sup>20</sup> According to his system model, the crucial factor influencing the power of a profession's knowledge base was its ability to "define old problems in new ways" (1988: 30). He argued that it was through abstraction (theoretical elaboration) that a profession constituted its work and staked jurisdictional claim over it vis a vis other professions. It was the subjective qualities (or cultural constructions) of the tasks that, according to Abbott, were the focus of interprofessional competition. Reinterpretations of problems or tasks were part of larger jurisdictional claims - "claims not only to classify and reason about a problem, but also to take effective action towards it" (1988: 38).

On the one hand, a task's basis in a technology, organisation, natural fact or even cultural fact provides a strong defining core. On the other hand, the profession reshapes this core as it pulls the task apart into constituent problems, identifies them for clients, reasons about them and then generates solutions shaped to client and case. Through this reshaping of objective facts by subjective means there emerges a fully defined task, irreducibly mixing the real and the constructed (Abbott, 1988: 57).

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<sup>19</sup> Krause (1989: 476) notes that Abbott is at his best in giving the sense of contingency, or particularity, that is often missing from sociological approaches to the professions.

<sup>20</sup> For discussions of how Abbott's "systems" approach can be adapted to particular aspects of professional activity see Brain (1991, 1994) on practical knowledge, Halpern (1992) on intraprofessional relations and Barker (1998) on gender.

Abbott emphasised that at each stage procedures of classification and abstraction were employed, and appropriate modes of relating the particular case to the formal knowledge system were adopted. This was the "cultural work" that had to be employed by the practitioner (MacDonald, 1995). Alongside this practical knowledge, there was the academic, formal, abstract knowledge system which must be "actively advanced" as it provided both legitimation and the scientific development that was necessary to maintain the professional jurisdiction of practice. According to Abbott, practical skill grew out of an abstract system of knowledge. The successful deployment of knowledge (ie. the successful exercising of professional judgement) required that a balance be achieved between abstractness and concreteness.<sup>21</sup>

Abbott's arguments about the shaping of professions within fields of interaction and the cognitive construction of professional work are useful for analysing how midwifery's claim to autonomy, articulated in the legal, state and public arenas, is based on a (re)conceptualisation of pregnancy and childbirth as 'normal', physiological processes. In Abbott's terms, midwifery challenged doctors' jurisdiction over maternity work by redefining the 'problem' of childbirth and the skills/expertise required to 'solve' it. Where the medical profession interprets pregnancy and childbirth as a potentially risky or pathological process requiring supervision by those with medical training and skills, midwifery defines it as a 'normal', physiological process which has been 'medicalised' by doctors. Midwifery knowledge and skill, it is claimed, provide midwives with a form of 'expertise' which enables them to facilitate the 'normal'.

Both definitions support claims to some form of jurisdiction over maternity work. Midwives, like doctors, are constructing the social problem/fact of childbirth into a

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<sup>21</sup> Abbott's distinction between abstract and concrete knowledge is similar to Jamous and Peloille's (1970) distinction between 'indetermination' (I) and 'technicality' (T). They argued that any occupation has an I/T ratio but those that claimed to be professions needed to be high on indeterminacy. Larson (1977) also drew on Jamous and Peloille in developing her argument about the need for professions to establish cognitive exclusivity in the market.



professional 'problem' for which they claim to have the knowledge and skills to provide the solution. Central to these different definitions is contestation over the meanings of 'normal' and 'abnormal' childbirth. In the midwifery definition, the majority of births are 'normal' and do not involve complications. This definition is deployed in conjunction with claims that midwives have the expertise necessary to facilitate this 'normal' process. These claims centre on midwives having a knowledge and skill base which enables them to assume responsibility, not only for facilitating a 'normal' pregnancy/birth, but also for determining when a pregnancy/birth deviates from 'normal' (see chapter four).

To turn childbirth into a 'problem' that falls within its jurisdiction, midwifery has therefore had to engage in 'cultural work' to ensure that clients, competitors, the state and the public acknowledge that the qualities of the problem warrant not only the granting, but also potentially the enhancing, of that jurisdiction. For midwifery, like other professions, this 'cultural work' has involved theoretical elaboration of its knowledge base. Historically, this formalising of its knowledge and training has meant a shift from midwifery as craft practice to midwifery as a form of 'specialist' nursing practice underpinned by a curative/medical discourse. Since 1990 it has involved the (re)constitution of midwifery as 'specialist' maternity practice with its own abstract knowledge base (see discussion on cognitive construction of 'expert' work).

An advantage of Abbott's approach is that it captures both the relational and cognitive aspects of professionalising strategies while also highlighting contingency and complexity. His notion of professions as competing, combining, coercing and sometimes cooperating is a more flexible analytic tool for understanding the interrelatedness of midwifery and medicine's struggles for jurisdiction over maternity work than more structuralist/monopolist approaches. An interactionist approach like Abbott's that recognises a multiplicity of interprofessional relationships, which are

interconnected or dependent, is useful for understanding the development of both competitive and collaborative relations between midwives and doctors since 1990 (which are described in part three of the thesis).

Abbott's approach is less useful, however, for explaining the role that the state has played in midwifery gaining autonomous status. According to Abbott's model, jurisdictions are initially negotiated in the workplace and then generalised through the establishment of such claims, firstly in the arena of public opinion, and then in the legal order (1988: 62-63). In this sequential process, success in the workplace and labour market precedes public and then statutory recognition. This does not describe the sequence of events leading to the introduction of midwifery autonomy. As chapters three and five of the thesis explain, it was the state's determination to get rid of established monopolies, and introduce competition amongst providers in the health sector in order to contain costs, that led to midwifery being granted legal autonomy. It was only after gaining greater control over its training and practice, that midwifery was in a position to achieve some 'success' in the workplace.

## **2.5 Professions and the state**

A concern with the importance of examining relations between professions and the state is evident in recent European literature on theorising professions (Torstendahl, 1990a; Burrage 1990). This concern is associated with a more general interest in the state as an entity with an explanatory power in itself, which cannot be reduced to class interests or individual motives (Evans et al., 1985).<sup>22</sup> European theorists have critiqued Anglo-American conceptualisations of professionalism as being ethnocentric and not appropriate to the study of Continental professions. According to Torstendahl (1990a:

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<sup>22</sup> This understanding of the state as an actor, which may formulate and pursue goals that are not simply reflective of the demands or interests of social groups, is developed in chapters three and five.

7), the Anglo-American bias has brought about a presupposition that professions should be "characterised by an anti-state attitude". This is problematic in the case of Continental and Scandinavian knowledge-based groups given their reliance on the state for both training and employment.

A related theme in the European literature was the need for theorising on professions that recognised historical and cultural variation (Collins, 1990; Burrage, Jarausch and Siegrist, 1990). This approach recognised that there has not been a "once and for all" professionalism in the United States or in Europe. The task, according to Torstendahl (1990a: 8), was to examine how professional activities - labelled professional or not - have changed in content and legitimation according to changes in national (state and market) contexts. He urged analysis of how knowledge-based groups behave in some specific ways in the most different social settings but how they were, at the same time, very dependent on the crucial variables of those social settings.

Knowledge transmission, type of knowledge base, state organization, clients, employment and possible a couple of more crucial variables have to be treated intensely in each case in order to clarify both the historical process in the development of certain knowledge-based groups and also the common grounds for such knowledge-based groups (Torstendahl, 1990a: 8).

Another way of conceptualising the relationship between professions and the state is offered by writers such as Johnson (1993, 1995) who use Foucault's concept of governmentality to argue against conventional theories which counterpose professions and the state.<sup>23</sup> According to Johnson (1995: 9), it was a misconception to view the relationship between state and professions as one existing between two pre-constituted subjects. Rather, he argued, these two realms of activity were inseparable, with

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<sup>23</sup> Halliday (1987) argues similarly that the legal profession does not merely relate to the state but directly performs some of its functions and can, in some respects, be considered part of the state. Rose and Miller (1992) draw on the concept of governmentality to discuss the effects of the British government's efforts to 'rationalise' the health services.

professional activities being processes of government. If the state/profession duality was eliminated, Johnson claimed that it did not make sense to think of professions as striving to secure greater autonomy in the face of state intervention. It was out of a complex interplay of political activities, including the struggle for occupational jurisdictions, that the state itself emerged (Johnson, 1993: 151).

This general concern with recognising the interdependence of state and professional activity is supported by arguments in this thesis which highlight the role that state actors have played in creating and enhancing midwifery's opportunities for autonomous practice. As noted earlier, these opportunities have arisen out of the interest that state actors had in providing more flexible, consumer-oriented and cost-effective primary health/maternity services. Recognising midwifery as a profession with legal jurisdiction over its training and practice enabled the state to introduce competition into the maternity sector and, having established an alternative provider, to contain costs by moving to a fixed-fee funding system (see chapter five).

This example supports an argument that the likelihood of a profession being 'successful' in its claims to greater autonomy and status is linked to those claims/interests, not only being compatible with broader social and economic interests of state actors, but also being more compatible than the claims/interests of competing professional groups. As MacDonald argued (1995: 33), a profession does not just mark out its domain in a bargain with the state; it has to fight other occupations for it, not just at the time, but before and after as well. This argument, which obviously picks up on a key theme of Abbott's, highlights competition between occupational/professional groups for support from the state for jurisdictional claims. It suggests that midwifery's 'success' was due in part to the medical profession's legal monopoly over maternity services no longer being compatible with state actors' objectives.

## 2.6 Cultural dimensions of 'expert' work

An emphasis on the specific nature of professional knowledge, and its relationship to professional work, has been evident in sociological writing on the professions (Freidson, 1986; Larson, 1977; Abbott, 1988). While earlier accounts recognised knowledge as a weapon or resource used by professionalising groups in the struggle for legitimacy and privilege, they tended to treat this knowledge either as a given or as a "mask for the play of social interests" (Hoffman, 1989: 208). A more contemporary approach is to see a profession's knowledge base as a highly variable and contingent outcome of the complex interactions that take place between professions, state actors and clients/consumers. Emphasis in this approach is on the embedding of knowledge in various professional forms which constitute and reproduce themselves in and through this process of interaction.

This sense of professions as emergent from a competitive political process, involving claims and counterclaims to particular types of knowledge and expertise, is a strength of Abbott's (1988) work. As noted earlier, his concern with the capacity a profession's knowledge base has for abstraction focuses attention on how profession's compete for jurisdiction through the cultural/cognitive construction of tasks involved in 'expert' work.<sup>24</sup> This emphasis on the cultural dimensions of expert work has been developed by writers such as Brain (1991, 1994) and Larson (1990) who have focussed on the production of knowledge as a constitutive component of a structure of occupational control that characterises professionalised occupations.

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<sup>24</sup> Johnson (1995: 17-18) regards Abbott as advancing beyond conventional sociological literature in focusing, not on the preconstituted professional subject seeking autonomy, but on the processes through which occupations constitute themselves, relative to others, as professions. He criticises Abbott, however, for conceptualising the state as a preconstituted reactive agent rather than itself an emergent property of the system.

In an approach similar to Abbott's, Brain (1991: 260) argued that professionalised occupations were distinguished, not by the possession of specialised/esoteric knowledge, but by the construction of a relatively autonomous domain of practical judgement.

What distinguishes professional work is not that professionals (individually) possess knowledge and authority but that they (collectively) construct the grounds on which they can exercise a certain kind of judgement, and make a point of it. This is the core of the profession's practical knowledge, which constitutes their capacity to identify a job to be done, to know how to go about doing it, and to recognise when it has been done appropriately (from their own perspective).

In analysing the profession of design in the United States, Brain (1994) examined the construction of a disciplinary framework within which the status of the architect was embodied in concrete practices. This involved the "articulation of a distinctive form of work and the ability, embodied in the work itself, to sustain a framework of interpretation which gave specific cultural content to professional design" (1994: 207). Brain's work highlighted the importance for a profession of having a knowledge base which not only lent itself to abstraction, when competing for or defending a jurisdiction, but also underpinned the exercising of practical judgement. This framework of judgement, or shared expertise, constituted the cultural work through which an occupational group constructed the intraprofessional coherence of its jurisdiction (Brain, 1991: 264).

The importance of both abstract and practical knowledge is discussed in this thesis, particularly in connection with the introduction of direct entry midwifery (DEM) training in Aotearoa/New Zealand (see chapter four). Unlike a profession which uses its formal knowledge base to constitute its work and stake jurisdictional claim over it vis a vis other professions, midwifery has been pushed into theoretical elaboration of its formerly tacit knowledge base as a consequence of obtaining legal jurisdiction over

childbirth. In gaining greater control over its training and practice, it has embarked on a shift from midwifery as nursing-based practice underpinned by a curative/medical discourse to midwifery as 'specialist' maternity practice with its own formal knowledge base and framework of practical judgement.

This shift has involved midwifery leaders and educators in abstracting a coherent and rationalised practice out of multiple possible ways of providing pregnancy/birthing care. In Larson's (1990: 37) terms, these leaders and educators are the credentialled experts who occupy the "core region" of midwifery's discursive field. This is the social location from which the truer discourse, which she explained as being the most theoretically coherent or epistemologically valid, is issued in defence of midwifery's dominant codes of practice.

At the core...what matters most is discourse itself, the production of true knowledge about that part of natural or social reality that the profession addresses, the defence that it makes of its own manner of address, as necessary means for accumulating capital (Larson, 1990: 38).

Using a Foucauldian approach, Larson was concerned with the relation of different categories of professionals within a particular field to the production and deployment of discourse. Like Brain, she was interested in the production of knowledge as a constitutive component of professional control. Larson argued that the discourse produced by a profession, which was derived from the formal knowledge base created at the core, provided a basis of mutual understanding amongst the various groups that constituted 'the' profession. This way of constituting expertise presupposed, as Larson pointed out, the parallel constitution of a lay public which had the knowledge that allowed them to understand the marks of expertise, that is, the social/cognitive map on which the experts' 'superiority' had been placed.<sup>25</sup>

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<sup>25</sup> It is useful to see these categories - 'professional', 'layperson' as discursive categories created through the use of binary logic. Thus the category 'professional' depends for its

Where Larson discussed the usefulness of Foucault for analysing professional projects at an abstract/theoretical level, Chua and Clegg (1990) and Witz (1994) demonstrated the relevance of these ideas for case studies on nursing.<sup>26</sup> Witz's work will be considered in the next section of the chapter because of its focus on gender. Chua and Clegg combined closure theory and discourse analysis in examining attempts by nurses in Britain to effect professional closure. Their analysis showed how discursive statements of the nursing professional project have historically constituted and transformed, and been transformed by, other aspects of professional practice (Chua and Clegg, 1990: 136). This explanation links the availability or rise of various professional discourses (which constitute different closure rules) with specific empirical occurrences or developments.

This concern with the availability, in particular historical junctures, of discursive resources for constructing professional identities and jurisdictions is useful for analysing how midwifery has endeavoured to construct a collective professional identity which distinguished midwives' philosophy, skills and services from those of other health professionals. In the context of Aotearoa/New Zealand in the 1980s and 1990s, discourses associated with feminism, consumerism and New Right economics have been drawn on by groups of midwives, maternity consumers/activists and state actors to (re)constitute midwifery as an autonomous form of maternity practice. This has involved the deployment of particular sets of discursive elements - such as 'partnership', 'continuity of care', 'woman-centred' - in (re)constituting midwifery as a gendered/feminist form of professional practice.

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existence on the 'opposite' category 'layperson'; one cannot be understood without the other. They are constructed as hierarchical oppositions; each with particular attributes and experiences. See Annandale and Clark (1996: 22).

<sup>26</sup> Further examples of Foucauldian-influenced analyses of professions and their knowledge bases include Nettleton (1992) on dentistry, Rose (1989) on psychology, Arney (1982) on obstetrics, Armstrong (1983) on medicine and Johnson (1994) on accountancy. For a discussion of Foucauldian approaches to analysing issues in the sociology of health and medicine, see *Foucault, Health and Medicine* (1997).



## 2.7 The gendering of 'profession'

Much of the theorising in the sociology of professions does not address the issue of gender (Hearn, 1982; Riska and Wegar, 1993). Some functionalist writers (eg. Etzioni, 1969) identified predominantly female occupational groups as "semi professions" in an attempt to locate them on a continuum of states of relative professionalisation. The argument was that while occupational groups such as nursing and social work may possess expert knowledge, practitioners generally operated in bureaucratic settings subordinated by other occupational groups (Manley, 1996). Their work was regarded as being more 'supervised' and 'applied' than the more theoretically informed and autonomous work of professionals (Abbott and Wallace, 1990). This way of categorising professional groups is problematic because it assumes some notion of what a profession essentially is. It also assumes that professions are gender neutral organisational forms.

This gender-blind approach to theorising professions has been critiqued by feminist writers (Crompton, 1987, 1990; Witz, 1986, 1990, 1992, 1994) who have attempted to rework theoretical perspectives developed initially without reference to issues of gender. Of particular relevance to this research project are the more recent arguments advanced by Witz (1994) in relation to attempts by nurses to establish a distinct and autonomous sphere of competence within the contemporary health division of labour. In this discussion Witz combined aspects of neo-Weberian closure analysis with her concern about the difference that gender made to the form and outcome of professional projects.<sup>27</sup> In an extension of her earlier work, she also showed how discursive strategies underpin occupational closure strategies.<sup>28</sup>

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<sup>27</sup> In *Professions and Patriarchy* (1992: 44-69) Witz develops Larson's approach in outlining a conceptual model of the specifically gendered dimensions of occupational closure. This model distinguishes between strategies of exclusionary, inclusionary, demarcationary and dual closure. Witz argues that exclusionary and demarcationary

Witz's analysis emphasised that professional projects were embedded in, and were mediated by, patriarchal structures that lent resources for the mobilisation of male power.<sup>29</sup> She argued that both the practical accomplishment of nursing work and the strategic aspirations of nurses must be located within the structural parameters of patriarchy, or a gender order of male dominance and female subordination.<sup>30</sup> In assessing the success or otherwise of nurses' occupational strategy, Witz said:

It is difficult to imagine a successful nursing challenge to medicine around the issue of practitioner autonomy without a challenge to the systematic devaluation of women's worth and women's work in society as a whole, particularly when the vision of an enhanced or expanded nursing role pivots around people-centred and caring skills which are saturated with gender-bias and systematically undervalued precisely because they are performed by women (1994: 38-39).

This emphasis on the patriarchal structuring of society, and the dominance of "male power", supports an oppositional construction of gender relations in which 'male' and 'female' appear as fixed, given categories with particular effects. This understanding of male interests/power as dominant and female interests/power as subordinate does not open up for analysis how different constructions of gender, of both masculinities and femininities, can be utilised as resources in a variety of contexts. It also offers limited analytic possibilities in terms of outcomes of female professional projects. Most

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strategies are engaged in by a dominant social or occupational group (typically male) in the hierarchy of closure, whilst inclusionary and dual closure strategies describe the responses of subordinate social or occupational groups (typically female).

<sup>28</sup> Witz acknowledges in the introduction to *Professions and Patriarchy* that a focus on discursive strategies can be used to illuminate the gendering process at work; that the concept of discourse provides a bridge between explanations of gender divisions which focus on ideology and those that focus on material practices.

<sup>29</sup> This point is noted by Davies (1996: 662).

<sup>30</sup> Witz (1994) refers to nurses' occupational strategy as one of dual closure with usurpationary (seeking to challenge medical definitions and control over what nurses know and do) and exclusionary (creating mechanisms of occupational closure which distinguish between those who can and cannot practice as a nurse) dimensions. She says that nurses traditionally sought to achieve these goals through credentialist (bid to define and institutionalise a distinctive knowledge base) and legalistic (attempts to secure state support for occupational autonomy) means.

crucially for this research, it does not help to explain how midwives have been able to use gender as a resource in their struggle for professional autonomy in the contemporary context while other predominantly female occupational groups, such as nurses, continue to experience gender as a constraint.

A more useful way of understanding or explaining the relationship between gender and professionalising activity is to conceptualise gender relations as being complex, dynamic and potentially unpredictable (Halford et al, 1997: 13). Rather than being fixed and given, gender relations are actively reproduced in a variety of ways at different levels of social/professional interaction and organisation. As Davies argued (1996: 664), gender operates at multiple levels; it gives meaning to, and affects, the formation and reproduction of organisations and institutions as well as having influence at the levels of interactions and identities.<sup>31</sup> This approach treats gender as a cultural resource which can be utilised in a variety of ways in the (re)constituting of identities and organisational arrangements. As Davies explained:

Gender has considerably more sociological purchase when viewed as one cultural resource among many, called upon in the process of creating and sustaining identities, utilised in daily interaction, available as image and metaphor in the shaping of organisational and institutional arrangements (1996: 665).

This conceptualisation of gender as a resource, rather than a relation of social domination or inequality, is supported by this case study of an almost exclusively female occupational group which has secured legal jurisdiction over its training and practice. Analysis shows how midwifery has been able to use the gender of its

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<sup>31</sup> This argument is consistent with other feminist writing (eg. Acker, 1990, 1992) that regards gender as being embedded in the constitution of all economic, social and cultural processes. According to Acker (1992: 250), 'gender' refers to patterned, socially produced, distinctions between female and male, feminine and masculine. She argues that gender is not something that people are, in an inherent sense, but is a daily accomplishment that occurs in the course of participation in work organisations as well as in many other locations and relations.

practitioners as a resource in a context where consumer groups were demanding more 'women-centred' maternity care and state actors were keen, for a variety of reasons, on responding to consumer demands. Claims that midwives were "the woman's advocate" and "the guardians of normal childbirth" were used in submissions made by consumer representatives in support of midwifery autonomy (see chapter three). These claims provide an indication of how midwifery autonomy was constructed by some groups as a gendered issue.

Similar claims were also made by midwifery leaders and maternity consumers/activists in their efforts to (re)constitute midwifery as a feminist form of professional practice (Tully et al., 1998). Central to this practice is the concept of a 'partnership' between midwives, as female health professionals, and women who share their understanding of birth as a normal life event (see chapter six). In positioning midwives and birthing women as 'partners' who shared responsibility for the pregnancy/birth, midwifery leaders drew on feminist understandings about the importance of women taking control over their lives and health in general, and their reproductive experiences in particular. Feminist concerns about issues of responsibility, control, empowerment and choice were put at the centre of midwifery's definition of itself as a profession with a "moral obligation to work in partnership with women" (NZCOM, 1993).<sup>32</sup>

Implicit in this construction is the assumption that midwives and women are homogenous groups that have mutual interests because of their shared gender status.<sup>33</sup> This assumption is reflected in a slogan adopted by the NZCOM: "Midwives need

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<sup>32</sup> These concerns are associated with second wave feminist writing (eg. Arms, 1977; Ehrenreich and English, 1979; Oakley, 1980, 1984; Scully, 1980; Kitinger, 1988) which referred to the way in which women's social experience (including health and health care) is mediated by the institutions of patriarchy, usually in oppressive ways. This scholarship was premised on a binary division between men and women, male and female, and sex and gender. For a discussion of the negative consequences of such distinctions, see Annandale and Clark (1996).

<sup>33</sup> See De Vries (1993) and Benoit (1994) for discussion of this issue in relation to American and Canadian midwifery.

women need midwives". While this slogan may reflect relations between some midwives and women/consumers associated with the college, it is problematic to suggest that it applies to all midwives and all women because of differences that exist within and between each of these groups. These differences relate to the various positions that groups of practitioners and maternity consumers occupy within the contemporary maternity/health care field. Where midwives may differ with respect to their opportunities for autonomous practice and their relations with birthing women, pregnant women may differ in their orientations to childbirth and their expectations of health professionals.

Recognition of differences within and between groups of midwives and maternity consumers/representatives associated with the NZCOM is an issue addressed in this thesis. Prior to 1990, the small number of politically active midwives and consumers involved in the struggle for midwifery autonomy were united in their resistance to medicalised childbirth. However, since 1990 this focus has been replaced by a variety of interests/concerns related to midwifery's efforts to consolidate its autonomous status in a context of health sector restructuring. Negotiating a mutually acceptable stance on these various professional and consumer interests has highlighted the difficulties involved in putting a model of professional/consumer 'partnership' into practise. Arguments for this model of practice, which draws on alternative understandings about the nature of professional knowledge, are discussed in the next section of this chapter.

## **2.8 'New' professionalism**

... old-style professionalism has had its day. The conditions in which it was created have changed out of all recognition (Stacey, 1992: 257).

An important theme running through some contemporary analyses of the professions is whether they are maintaining their position and legitimation or whether that position is

being eroded or even diminished (eg. Greenwood and Lachman, 1996; Broadbent et al., 1997). These concerns resonate with the arguments outlined earlier in this chapter about the 'deprofessionalisation' of professions as part of a more general trend towards rationalisation and codification of expert knowledge (Wolinsky, 1993). However, rather than seeing the contemporary changes in the structuring of expert work as the reversal of a process of professionalisation, this literature examines how changes in the role and ways of organising professional activity reflect the new circumstances.

An example of how these "new circumstances" are impacting on professional activity in the area of health was described by Bury (1998: 24-25) who noted a shift from medical scientific concerns with disease to more subjective concerns with health. He argued that the power of medicine in the modern era was now seen to be giving way to more pluralistic structures in which "voices once unheard now emerge as new sources of influence". Bury gave, as an example, the health of women. Once regarded as the 'object' of rationalizing medical power, women's health was now being reconstructed by "voices from below" in the shape of the women's movement.

Health promotion, consumerism and alternative medicine, together with a diminution of the power of the medical profession, are held to add a powerful impetus to the processes at work. In this way, 'heterogeneity' re-enters everyday life and displaces forms of professional and expert discourse from their dominant position. Difference rather than 'abnormality', and pluralism rather than unrivalled professional power, now define postmodernity as it unfolds on a global scale (Bury, 1998: 24-25).

Of particular interest in the professionalism literature is how the legitimacy of, and actual control over, specialised knowledge seems to be changing in many professions. One aspect of this changing status of specialised knowledge is the acknowledgement that clients have become sources of knowledge for professionals and, at times, even co-producers of the professional services they seek. According to Greenwood and Lachman (1996: 565), this recognition that clients have control over knowledge that

may be important for producing the professional services induces professional organisations to form "downstream alliances" with clients in order to regulate and secure access to such knowledge. These alliances, as they noted, may impinge on the way that professional work was organised and reflect on the control professionals had over specialised knowledge, and hence on their power over clients.

This concept of clients as co-producers of professional services has been identified as particularly appropriate to the fields of health and welfare. As noted earlier, Stacey (1992) argued that the medical profession must abandon "old-style" professionalism because patients are increasingly unprepared to accept the subservient position medicine has historically afforded them. She urged doctors to listen to what patients say and to understand the way they see things ie. their conceptual framework. Other advocates of a 'new' approach to professionalism (Davies, 1995; Williams, 1993; Hugman, 1991) claimed that it draws on alternative assumptions about knowledge, including that derived from experience and intuition, to constitute more equitable professional/client relations than those associated with a more orthodox or traditional form of professionalism.<sup>34</sup>

These critics of old-style professionalism argued that it was the prioritising of a scientific/rational epistemology which positioned professionals as "experts" whose authority rests on their possession and control of problem-solving knowledge. In the 'new' professionalism framework, recognition was given to the knowledge and experience of the client as well as the professional. The professional was positioned as a reflective carer/practitioner whose task was to support, guide, and empower the client in a more equitable, interdependent relationship. The claim was not that the professional's knowledge base abandoned all formal/scientific knowledge but that it did

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<sup>34</sup> Hugman's use of the term 'democratic' rather than 'new' professionalism is useful in that it does not suggest such discontinuity between a previous model and the reformed one.

not afford this knowledge the same epistemological priority that it had within the 'old' model of professionalism.

Arguments about the usefulness or relevance of this 'new' framework for professional practice have been voiced in relation to the direction being taken by occupations such as nursing and social work.<sup>35</sup> These occupations share concerns regarding (a) the implications for predominantly female occupations of a model of professionalism which is based on a rational, scientific, instrumental and arguably masculinist approach to knowledge and (b) the reconceptualising and revaluing of 'caring' work which is the basis of the services they provide. Writers concerned about the professionalising strategies of these occupations have argued that 'old' professionalism is outdated, inward looking and monopolistic and not suited to client needs and demands in a contemporary context. For example, Davies (1995: 152) urged nurses to consider:

... an advance into old professionalism is an advance into a cul de sac. There is too much in the model that is directly antithetical to what nurses wish to do. Nurses would be better engaged in joining the growing army of those who wish to build a new professionalism from the ashes of the old.

In constituting midwives as autonomous professionals who work in 'partnership' with clients, midwifery leaders and educators can be seen as acting on claims and relations associated with 'new professionalism'. As noted earlier, the 'partnership' model was adopted as a consequence of the political support given to the struggle for midwifery autonomy, and direct entry midwifery training, by women associated with maternity consumer/activist groups (see chapter three). Putting this model into practise has involved significant changes in the social relations and professional practices through which midwifery is institutionalised (Tully et al., 1998). Most notably, it has led to

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<sup>35</sup> See Salvage (1992) for discussion of 'partnership' as a central element in a professional reform movement called 'New Nursing'. Writing in the context of Aotearoa/New Zealand, Christensen (1990) provides a theoretical model using 'partnership' as the basis of nursing practice.



consumers being able to not only join the NZCOM, but also participate in policy-making and professional review processes (as described in chapter one).

Post-1990 this model of practice provides midwives with an important means of differentiating their services from those offered by other providers in the competitive primary maternity market. For practitioners looking to secure a niche for their services, there are advantages in positioning themselves as 'partners' with women in childbirth and in maternity politics. A model of professional practice which constructs the client as active, knowledgeable and gendered opens up a space for different jurisdictional claims over the tasks and expertise involved in the work. By putting the birthing woman/client rather than the practitioner at the centre of the 'normal' birth process, this model helps midwifery to differentiate its practice from the maternity services provided by medical practitioners.

In keeping with arguments outlined in this chapter about the cognitive/rhetorical construction of 'expert' work, this distinction between 'old' and 'new' professionalism can be seen as a false dichotomy. The 'new' framework of professional practice is a continuation of the 'old' in that it uses an occupation's knowledge base, albeit a differently constructed one, to strengthen its position in the labour market. While 'new' professionalism may be the basis for more equitable relations between practitioners and clients, it still provides a framework of practice which can be used by one group to construct its work in a particular way in order to make claims over it vis a vis another group/profession. In this sense the reformed model of professionalism, with its different constitution of 'expertise', is strategic rather than 'new'.<sup>36</sup>

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<sup>36</sup> This argument is similar to that made by Witz (1994: 39) in relation to the discourse of 'care' in nursing.

## Part Two

Negotiating autonomy:  
policy and organisational structures

## **Chapter Three**

### **The Nurses Amendment Act: The state and patterns of professional control**

#### **3.1 Introduction**

Maternity work in Aotearoa/New Zealand was opened up to competition between midwives and doctors in the 1990s. After decades of holding legal jurisdiction over the provision of maternity services, the medical profession was confronted with competition from an autonomous midwifery profession. Crucial to the activity of midwives as an autonomous professional group able to compete with doctors for the care of birthing women was the Nurses Amendment Act 1990. This legislation was the outcome, not only of struggles between doctors and midwives throughout most of this century for control of maternity care, but also changes in health policy which focussed attention on the cost effectiveness and accountability of services.

Concern expressed by politicians and policy makers in Aotearoa/New Zealand in the 1980s about the funding and delivery of health services was similar to that voiced by their counterparts in other western countries (Ham et al., 1990; Klein, 1995). Faced with budgetary constraints but an ever increasing demand for services, health policymakers were obliged to consider similar cost containing strategies (Ashton, 1992, 1995; Beaglehole and Davis, 1992; Bowie and Shirley, 1994; Fougere, 1994b). These strategies, which were in keeping with measures being introduced into other areas of the public sector, included various forms of rationalisation and cost-shifting which

aimed at containing and controlling spending within the health sector. The implementation of these strategies by state actors had implications for patterns of professional control and autonomy amongst health care providers.

This chapter examines how the working out of these global/international problems in the health sector in the political and economic context of Aotearoa/New Zealand provided an opportunity for significant change in the area of maternity care. It argues that it was a shift in health policy towards cost effectiveness, accountability, competition and consumer choice that enabled the opening up of maternity care to multiple providers. In lifting the restrictions on autonomous midwifery practice and funding midwives on the same basis as doctors (ie. as private practitioners), state actors not only responded to consumer demands for increased choices in maternity care but also introduced contestability, and arguably greater efficiency, into the provision of maternity services.<sup>1</sup>

This analysis of how the Nurses Amendment Act 1990 came about, and the consequences for midwives' professional status, shows how the forms of control that professional groups such as doctors and midwives have over their work is shaped in important ways, although not exclusively, by their relations with state actors. By examining how maternity work came to be dominated by doctors in the 1930s, and opened up to midwives in the 1990s, this chapter demonstrates how these forms of professional control change over time (ie. are historically contingent) as the policies instituted by state actors change. It shows how the constitution of professional expertise or autonomy is the outcome of a competitive political process involving a complex combination of occupational strategies, government policies and shifts in public opinion (Johnson, 1995).

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<sup>1</sup> Contestability in maternity care involves two alternative professional groups being legally permitted to provide maternity services on their own responsibility. See Douglas (1990).

### 3.2 The Nurses Amendment Act 1990

With the passing of the Nurses Amendment Act 1990 midwives in Aotearoa/New Zealand regained the legal right to practice as independent birthing practitioners. This legislation, which was introduced by the then Minister of Health, Helen Clark, enabled a midwife to take responsibility for the care of a woman throughout her pregnancy, childbirth and the postnatal period and to be entitled to a state subsidy for doing so. In lifting the restrictions on midwifery practice, it removed the medical profession's exclusive right to supervise all births. This right had been secured legally in the Nurses Act 1971 which made it an offence to carry out obstetric nursing in any case where a medical practitioner had not taken responsibility for the care of the patient.<sup>2</sup>

In introducing the bill into parliament in November 1989, Helen Clark said:

In recent years there has been a consistent message from various groups and organisations that childbirth is a natural process, and that a woman should be able to choose to have a midwife deliver her baby without the need for a woman to also be under the care of a medical practitioner (New Zealand Parliamentary Debates, 1989: 13479).

She argued that with the development of medical technology there had been a trend towards treating pregnancy and labour as an illness. This had resulted in an increasing amount of medical intervention in the management of normal pregnancy which had contributed to the erosion of the midwives' role and had proven to be costly, and in many cases, inappropriate. The amendment to the legislation would, according to

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<sup>2</sup> The Nurses Act 1977, which was the focus of the 1990 amendment, retained the same provision for offences relating to obstetric nursing. An amendment to the Nurses Act in 1983 prevented midwives without a nursing registration from working as domiciliary midwives. Those domiciliary midwives who were not registered as nurses, but who held contracts with the Minister of Health prior to 1 April 1984, could continue their practice outside of institutions.

Clark, enable midwives to provide a low-technology childbirth service to meet the needs of women with low-risk pregnancies.<sup>3</sup> It would also facilitate changes already planned by area health boards that wished to make childbirth services more flexible and consumer-orientated. Women would have the choice of accessing the services of either a midwife or a general practitioner.

The Minister's arguments were supported by women members of parliament from both sides of the House including Judy Keall (Labour), Katherine O'Regan (National) and Jenny Kirk (Labour). Each of the MPs endorsed the view that midwives had the knowledge and skills (derived from postgraduate nursing training) to provide independent care for women with 'normal' or low risk pregnancies and births (New Zealand Parliamentary Debates, 1989: 13482-13485). They regarded medical practitioners as having an important role to play when there was any abnormality or illness. They also spoke of the importance of women having choice with regard to their maternity caregiver. References to midwives being skilled in working independently from the hospital environment, and being professionally accustomed to close communication with general practitioners, testified to the effectiveness of lobbying by midwifery, home birth and maternity consumer activists for the legislative change.<sup>4</sup>

The Opposition supported the introduction of the bill and its further consideration by the Social Services committee.<sup>5</sup> Deputy leader Don McKinnon raised some concerns

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<sup>3</sup> The Nurses Amendment Bill consisted of two clauses which amended section 54 of the Nurses Act 1977. By adding the words - "or registered midwife" - after reference to "medical practitioner", it permitted a registered midwife to assume the same responsibility as a doctor in relation to the provision of sole care to a woman throughout pregnancy, childbirth and the postnatal period.

<sup>4</sup> A central figure in the struggle for midwifery autonomy was high profile domiciliary midwife, activist and writer, Joan Donley, who had lobbied her local MP, Helen Clark, for years. Reflecting back on the 1990 legislation at a NZCOM conference in 1996, Clark said: "Joan Donley and her sisters thought the unthinkable; they even dared me to think the unthinkable".

<sup>5</sup> The Nurses Amendment Bill was referred to the Social Services Committee on November 9, 1989. This committee was chaired by the MP for Glenfield (in Auckland), Judy Keall. Committee members included Jenny Kirk (National), Russell Marshall (Labour), Don McKinnon (National) and Katherine O'Regan (National).

about the possibility of midwives needing prescribing rights and access to laboratory services (New Zealand Parliamentary Debates, 1989: 13481). He also questioned whether the New Zealand Medical Association (NZMA) had been consulted in the drafting of the bill. Clark replied that midwives would not need to prescribe drugs because complications in pregnancy would be more properly handled by medical practitioners (New Zealand Parliamentary Debates, 1989: 13485). She said that consultation was not sought with the NZMA with regard to the bill, but the association was asked for submissions on the review of the Nurses Act as a whole.

The Social Services select committee received 99 submissions on the Nurses Amendment Bill from health professional organisations (the NZCOM, the NZNA, the NZMA, the RNZCOGs and the Domiciliary Midwives' Society) area health boards, home birth associations, women's/community health groups and individuals (63). The submissions fell into two categories: those supporting the bill and those supporting the principle of autonomy for midwives but raising specific concerns (Social Services Committee, 1990: 4). The arguments presented in these submissions show how different discourses or understandings about childbirth are utilised by groups of actors to support claims about how, and by whom, maternity care should be provided. They also map the different positions held by interested groups in relation to midwifery "autonomy".

#### **(a) Submissions**

Submissions from various women's health organisations, home birth associations and midwives' groups criticised medical intervention in normal births and supported midwifery autonomy as a strategy for widening choices with respect to maternity care. For example, the Auckland Women's Health Council (1989: 1) said:

...we endorse midwifery autonomy because midwives are recognised as the woman's advocate and as the guardians of normal childbirth - and women have had enough of routine medical interventions in childbirth.

These submissions argued that childbirth was a normal physiological function or process which, in the majority of cases, only required observation and supportive care from a health practitioner. In drawing on this discourse of birth as normal/ natural/ low-risk, the advocates of midwifery autonomy were positioning midwives as the practitioners with the skills and/or competence to provide the appropriate care. In doing so they were also defining doctors as the most appropriate providers of abnormal, high risk obstetric care. They argued that the amendment would enable midwives, as independent practitioners in the primary health sector, to provide women-centred, continuous (non-fragmented) care at less cost than the medically oriented maternity system. Access to independent midwifery care would be of particular advantage to rural women and those planning home births.

The arguments put forward in these submissions were also 'gendered', as the quotation suggests. It was not simply a case of 'normal'/non-interventionist versus 'abnormal'/interventionist maternity practices. In constituting midwives as the "woman's advocate", and the providers of "women-centred" care, these groups were using a particular construction of gender as a discursive resource. Claims about the appropriateness of maternity care provided by women health professionals for women clients were likely to be effective in a context in which there was considerable public concern (following the Cartwright Inquiry) about the lack of accountability of the medical profession, especially in relation to women's health care (discussed later in chapter).

In its submission, the NZCOM (Auckland region) took issue with the fact that a midwife was legally defined as an 'obstetric nurse' (NZCOM, 1989: 1-2). It claimed



that an obstetric nurse was a nursing attendant to an obstetrician ie. she was trained in the medical model of childbirth and worked under the direction of a doctor whose role was to care for the abnormal in pregnancy and birth. However, according to the NZCOM, a 'midwife' was an expert in the normal, physiological process of pregnancy and birth. Using the World Health Organisation (WHO) definition of a midwife, the college argued that she was trained "to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and infant" (NZCOM, 1989: 1-2).<sup>6</sup>

Another issue raised by the college was the potential cost effectiveness of autonomous midwifery services. In utilising arguments about cost efficiency to critique doctors' control over childbirth, the college was linking its professional interests with broader political concerns about the funding and delivery of health/maternity services. It endeavoured to do this in two ways. Firstly, it highlighted the high costs involved in providing unnecessary levels of abnormal obstetric care and the economic advantages of allowing midwives to provide autonomous maternity services within the primary health sector. Secondly, it drew attention to the additional costs incurred in a maternity system in which there was a duplication of medical and midwifery services.

The college claimed that almost one quarter (24.8 percent) of women in Aotearoa/New Zealand had 'abnormal' births, either a caesarean section (11.1 percent) or a forceps delivery (13.7 percent).<sup>7</sup> On the basis of a caesarean section costing a minimum of \$1500, it argued that such a high rate of abnormal births was a heavy economic drain on the health budget. This drain was not only due to the actual medical and anaesthetic

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<sup>6</sup> In its submission on the review of the Nurses' Act, the NZNA supported an amendment to permit midwives to assume full responsibility for their clients' midwifery care (NZNA, 1989).

<sup>7</sup> These figures came from the National Health Statistics Centre, Hospital and Selected Morbidity Data, Annual Reports.

costs, but also because such births required a longer stay in hospital and a high percentage of babies from such births needed intensive care in the neonatal unit (NZCOM, 1989: 4-5). By contrast, overseas experience showed that intervention rates were lower where midwives played a major role in maternity care. For example, in Holland the caesarean section rate in 1984 was 5.4 percent.

The NZCOM alleged that Aotearoa/New Zealand was probably the only country in the world where a doctor was legally entitled to a state paid subsidy to watch a midwife deliver a baby. It cited a home birth situation in which the domiciliary midwife received \$225 for attendance at a labour and birth of up to six hours, plus \$37.50 per hour thereafter. The doctor who attended the birth as part of his/her 'responsibility for the care of the patient' received \$245 for one and a half hours' attendance. This, according to the college, was about the time required to watch the birth, examine the baby and participate in the celebrations (NZCOM, 1989: 6). It argued that payment to doctors for work done by midwives also occurred in maternity and obstetric units where midwives were paid a salary by the area health board.

In the delivery units, both GPs and obstetricians not only rely, but are dependent on, the midwife's clinical skill and judgement. This use of her skills but denial of her real role results in duplication of services and substantially increases costs. For instance, if a midwife delivers a woman in the care of a GP or an obstetrician, ie. a private patient, the doctor can claim his/her fee provided s/he puts in an appearance within a reasonable time after the birth (NZCOM, 1989: 6-7).

The college drew the select committee's attention to some research done by the supervisor of the Bay of Islands maternity annexe on the amount of money paid to doctors for work done solely by midwives over a four month period in 1988. During this time there were 122 births of which 80 (or 65 percent) were cared for and delivered by midwives. The only contact with the doctor was by telephone to advise him/her of progress. Of the remaining 42 births, all of which were attended by a doctor, only 29

had some degree of 'abnormality' which required medical assistance. The research concluded that the government had paid \$29,890 (122 x \$245) to doctors when only \$7,105 (29 x \$245) was necessary. The lack of midwifery autonomy had, according to the study, cost the government the unnecessary payment of \$22,785 to duplicate services (NZCOM, 1989: 7).

Submissions described by the select committee as "supporting the principle of autonomy for midwives" nonetheless expressed concerns about midwives' level of training and their competency to recognise complications that might arise during pregnancy and childbirth. These submissions, primarily from doctors' professional associations, drew attention to the potential risks they saw associated with pregnancy and childbirth. According to the New Zealand Medical Association (NZMA), major risks could arise in "low risk obstetrics". Two such examples were postpartum haemorrhages and babies born with unexpected respiratory diseases such as the umbilical cord around the neck.

Such acute emergencies require expert care by a team eg. doctor and nurse. Doctors are expected to train for the diploma of obstetrics and to become competent in handling these situations. To expect a midwife, no matter how experienced, to cope with such an emergency, particularly in a domiciliary environment, is potentially extremely dangerous (NZMA, 1989: 2).

It is evident from this statement that childbirth was being constituted as a potentially high risk event in which medical expertise (as evidenced by medical qualifications) was necessary to manage the "acute emergencies" that could arise. Interestingly, the expertise required to cope with such emergencies involved the skills of a doctor and a nurse rather than a midwife. This idea of a "team" approach was also promoted in the submission from the Royal New Zealand College of Obstetricians and Gynaecologists (RNZCOG). The specialists suggested an initial assessment of the pregnant woman should be made by a medical practitioner - "with subsequent modification of future

management if the assessment proves normal" (Social Services Committee, 1990: 5). This proposal aimed to secure medical control over team care with the doctor being the arbiter of whether the pregnancy was 'normal' or otherwise. Midwives could provide 'autonomous' care if and when a doctor said so.

The understanding of pregnancy and childbirth as potentially risky and most appropriately the responsibility of a doctor was not confined to the medical profession. The submission from the National Council of Women of New Zealand argued that the medical profession should be responsible for determining the suitability of pregnant women for midwifery care. While having no objection to midwives doing most of the antenatal, birthing and early postnatal care by themselves, the council considered it should be a responsibility delegated by a doctor (National Council of Women of New Zealand, 1990: 4). Members did not think that midwives had the expertise to decide in every case whether a pregnant woman should be placed in the 'normal' or 'abnormal' category. Despite these reservations, the council did support the amendment.

The arguments in these submissions highlight the co-existing and contested discourses on birthing which are utilised by health professionals and their supporters in making jurisdictional claims over maternity work. Each group articulates a particular understanding of childbirth that positions or constructs an appropriate role for some actors and delegitimises others (Davies and Harre, 1990). In defining birth as a normal/natural physiological process, midwives (and their consumer supporters) positioned themselves as having particular non-interventionist skills that were necessary to provide the most appropriate care. In doing so they challenged the legitimacy of doctors' medicalised maternity care for the majority of birthing women. To defend their position doctors constituted pregnancy and childbirth as potentially risky conditions which could only be considered 'normal' in retrospect and were therefore most safely managed with medical expertise.

### **(b) From Bill to Act**

During the hearing of evidence before the select committee, it became evident that midwives needed to be able to provide a range of maternity-related services to ensure the safety of mother and child (Social Services Select Committee, 1990: 7-8). These included the administering of medicines commonly used in low-risk pregnancies and childbirth, the ability to call for routine diagnostic laboratory tests and to claim associated social security benefits, and the ability to transfer clients to an obstetrician or a hospital, if necessary. To enable registered midwives to provide such services required amendments to five Acts and six sets of regulations.<sup>8</sup> In reporting back to the House in May 1990, the select committee chairman recommended that the amendments be drawn up in a supplementary order paper for consideration by parliament.

This move was vigorously opposed by Opposition deputy leader Don McKinnon who wanted both the Nurses Amendment Bill and the Government's supplementary order paper referred back to the select committee for further submissions from appropriate groups (New Zealand Parliamentary Debates, 1990: 1806-1807). Health Minister Helen Clark gave an assurance that there would be further discussion between the select committee and the relevant professional groups over the supplementary order paper. This discussion duly took place in July 1990 and further amendments were

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<sup>8</sup> Amendments were required to the following Acts: the Nurses Act 1977, to enable the Nursing Council to investigate complaints against registered midwives in relation to the Social Security Act 1964; the Social Security Act 1964, to allow registered midwives to claim maternity and pharmaceutical benefits; the Misuse of Drugs Act 1975, to allow registered midwives to prescribe the controlled drug pethidine; the Medicines Act 1981, to allow registered midwives to have possession of prescription medicines and the Area Health Boards Act 1983, to allow area health boards to enter into agreements with registered midwives about the treatment of patients in a hospital maternity ward or maternity annexe. Amendments were required to the following regulations: the Social Security (Laboratory Diagnostic Services) Regulations 1981, to permit registered midwives to order a range of laboratory diagnostic tests as specified in the regulations; the Social Security (Pharmaceutical Benefits) Regulations 1965; the Misuse of Drugs Regulations 1977; the Obstetric Regulations 1986; and the Medicines Regulations 1984. See Department of Health (1990).

introduced.<sup>9</sup> At the second reading of the bill in August 1990, Clark introduced another amendment which enabled the introduction of experimental direct entry midwifery (DEM) training programmes in two polytechnics.<sup>10</sup>

The introduction of DEM training was highly significant in that it created an opportunity for midwifery to consolidate a professional identity independent from nursing (see chapter four). While midwifery was a postgraduate nursing qualification, it was difficult for midwifery leaders and educators to separate the practice and the philosophy of the two professions. However, with midwifery training offered at undergraduate level alongside nursing training, they were clearly different career options. While the Nursing Council of New Zealand did not oppose midwifery autonomy, no doubt because it offered career opportunities for nurse/midwives, it regarded the supplementary order paper relating to the introduction of experimental DEM training programmes as a "bombshell" (Burgess, 1996). Of particular concern was the lack of opportunity for consultation over the issue (Papps and Olssen, 1997: 170) (see chapter four).

When the Nurses Amendment Act was passed, after its third reading in August 1990, midwives gained the legal right to not only perform a range of services related to primary maternity care but also claim from the state-funded maternity benefit according to the same schedule of fees as general practitioners.<sup>11</sup> Midwives could choose to

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<sup>9</sup> This supplementary order paper repealed section 58 of the Nurses Act 1977 which related to the authority of the Ministry of Health over midwives and obstetric nurses outside of hospital boards; amended section 106 of the Social Security Act 1964 to include a woman's right to have a doctor or a registered midwife or both with all fees in respect of maternity benefits paid by the Department of Health; and amended section 111 of the Social Security Act 1964 to add the NZCOM as the body with the authority to negotiate fees for independent midwives with the Minister of Health.

<sup>10</sup> Further discussion of Helen Clark's influence on the introduction of direct entry midwifery training despite opposition from within nursing is included in chapter four.

<sup>11</sup> The maternity benefits schedule of fees was fixed by way of annual negotiation between the Department of Health and the medical profession. Following the amendment to the Social Security Act 1964, the scale of fees could be fixed by agreement between the NZMA, the NZCOM and the Minister of Health. See chapter five for discussion of the difficulties

provide domiciliary and/or domino care, either independently or in a shared arrangement with a general practitioner or a specialist obstetrician. Reimbursement for these forms of practice was by means of the maternity benefits, using the same process as medical practitioners, or the domiciliary maternity benefits.<sup>12</sup> Midwives could also be employed in hospitals to provide antenatal, birthing and/or postnatal care on either a rostered or caseload basis. Hospital midwives were employed on salary by area health boards, with their pay and conditions negotiated by the unions.<sup>13</sup>

By giving midwives the right to practise autonomously, state actors ended the medical profession's jurisdictional monopoly over primary maternity services. Attention to the state's role in shaping patterns of professional autonomy and control in maternity care requires analysis of how particular forms of professional autonomy or jurisdiction become embedded in the structure of the health/maternity system (Fougere, 1993). This involves an examination of the way medical dominance over the provision of childbirth services became embedded in the structure and organisation of those services in the 1930s. The dominance that doctors, both general practitioners and obstetricians, secured over maternity care significantly shaped how, and by whom, aspects of that care were provided. It was therefore implicated in the various concerns that emerged amongst groups of service users, health professionals and state actors about effecting change in the provision of those services.

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involved in negotiating a new fees schedule following the introduction of midwifery autonomy.

<sup>12</sup> The domiciliary midwifery benefit was introduced in 1939 to reimburse midwives who attended women in homebirths and for 14 days afterwards. The fee-for-service schedule was amended in 1986 after considerable lobbying from consumer groups. Following the Nurses Amendment Act, the fee schedule for this benefit was the same as that for the maternity benefits.

<sup>13</sup> The NZCOM was formed to represent the professional interests of all midwives. However, industrial representation, particularly for hospital midwives employed on the same contracts as nurses, remained with the NZNA.

### 3.3 Legacy of 1938

Women in Aotearoa/New Zealand have had free access to medically supervised maternity care since a tax-funded public health system was introduced through social security legislation in 1938 (Cheyne et al., 1997; Ashton, 1992; Fougere, 1993). This legislation aimed to provide all citizens with access to free health care on the basis of 'need' rather than the ability to pay. The health regime that emerged from this legislation was, according to Fougere (1993: 116), a partial compromise between a reforming government and a resistant medical profession. It involved secondary/hospital services being financed from taxation, but primary care being funded through a variety of patient subsidies which covered all or most of the cost of a consultation.<sup>14</sup>

The doctors resisted state funding of health care in case it undermined their direct, fee-for-service relations with their clients. They were also concerned about state actors having greater involvement in, and control over, their practice. One consequence of the new health sector regime was to entrench those forms of professional autonomy and control that doctors had already secured (Belgrave, 1991). According to Fougere (1993: 117), this entrenchment was most obvious in the area of primary care.

General practitioners continued to enjoy the right to practice where they chose, as they chose, for the prices they chose, while being able to draw on extensive state subsidy of their fees and of the resources, especially pharmaceuticals, that they used in their practice of medicine.

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<sup>14</sup> The GMS (general medical services) benefit, which was introduced in 1941, represented about 75 per cent of the doctor's total fee. The pharmaceutical benefit, introduced in the same year, covered the full cost of pharmaceuticals prescribed.



An important aspect of primary health care, which general practitioners had fought hard to have a controlling influence over, was the provision of maternity services. Throughout the 1920s and 1930s doctors had struggled, primarily with the Health Department, over the provision of pregnancy and birthing services (Papps and Olssen, 1997; Fougere, 1994a; Mein Smith, 1986; Donley, 1986). This struggle centred on whether doctors or midwives were the most appropriate providers of maternity care. It involved contestation between the various groups over the meaning of childbirth - whether it was a normal life event most appropriately managed by midwives or a pathological condition requiring medical supervision. Each definition involved a different understanding of the tasks and skills involved in normal obstetrics and the expertise required to deal with them.

In the early 1920s midwives had an ally in the Department of Health which supported a state-funded, midwife-run maternity service modelled on the Dutch system.<sup>15</sup> Leading department doctors believed that confinements could best be carried out by trained women who were more patient than men, did not have to consider the exigencies of general practice and, most importantly, did not use forceps in deliveries (Mein Smith, 1986: 44). Not only did midwives not use forceps and other forms of "meddlesome midwifery", but they were also required to use the standardised sterilisation techniques which the department had introduced in 1924 to combat the spread of puerperal sepsis or blood-poisoning. This condition was the most important single cause of maternal mortality in childbirth.<sup>16</sup>

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<sup>15</sup> Midwives in Aotearoa/New Zealand occupied a central position in the maternity system in the early decades of this century largely because of their employment in the seven state-operated St Helens hospitals. These hospitals, which were established between 1905 and the mid 1920s, provided both training for midwives and a high standard of obstetric care for mothers struggling to rear families on small incomes. They consistently recorded the lowest maternal mortality rates in the country. See Mein Smith (1986: 117).

<sup>16</sup> The maternal mortality rate peaked at 6.48 per 1000 live births in 1920 - a rate higher than in any other developed country except the United States.

Other strategies implemented by the department to combat maternal mortality included the provision of antenatal care for all mothers, the inspection of private hospitals and improvements in the training of doctors and midwives. While there were aspects of this campaign which combined to benefit doctors in their pursuit of control over obstetrics, the overall effect of the reforms was to threaten their professional independence. As Fougere noted (1994a: 152), the requirement of aseptic techniques and the inspection and regulation of hospitals not only threatened the livelihoods of doctors who owned and operated private hospitals but also potentially subjected their practice to scrutiny and control.

Doctors responded to the department's reforms, and the increasing status of midwifery practice, by forming the Obstetrical Society. Under the leadership of Dr Doris Gordon, the society sought to restore public confidence in doctors as the most appropriate providers of obstetric care (Mein Smith, 1986). To counter the department's claim that doctors' obstetric practices were to blame for the spread of puerperal sepsis, it argued that the source of the infection was the woman herself. According to the society, the infection arose spontaneously and was not preventable. Therefore, it argued, it was not only inappropriate to blame medical practitioners for the maternal mortality crisis but also to subject their practice to increasing scrutiny by the state.

To forestall the possibility of midwives assuming full responsibility for normal maternity care, the doctors claimed that pregnancy and birth were pathological conditions requiring medical supervision. By defining childbirth as an illness the doctors sought to establish themselves as the most appropriate providers of maternity care. This claim was supported by the establishment of a chair in Obstetrics and Gynaecology at the Otago Medical School in 1931 and improvements in the obstetric training provided for medical students. However, while these strategies contributed to raising public support for medicalised maternity care, it was an aspect of occupational

licencing that secured doctors' dominance over childbirth (Mein Smith, 1986; Fougere, 1994a: 154). Only doctors could administer the anaesthetic drugs necessary to offer women pain-free childbirth.

Another significant area of maternity work over which doctors made a successful professional claim in the 1930s was that of antenatal care. Using a strategy similar to that employed to medicalise birthing care, doctors argued that modern antenatal work demanded technical expertise superior to that of nurses and midwives. Claims were made that the antenatal care provided by Plunket nurses was incomplete and inadequate and that nurses should "leave the true professional antenatal work alone" (Mein Smith, 1986: 96). By 1935 only 11 of the 37 public antenatal clinics were conducted by the Plunket Society. The others were attached to St Helen's and general public hospitals where there was close supervision by medical staff, including specialist obstetricians.

By the mid-1930s doctors had secured a controlling influence in obstetrics. Most women had their babies in hospital with a medical practitioner in attendance (Mein Smith, 1986: 119). Registered midwives and maternity nurses worked increasingly as doctors' assistants (Parkes, 1991: 165). The securing of medical dominance over the field of maternity care was the outcome of a complex reworking of relations between doctors, midwives, state actors and users of maternity services. As this discussion of key developments has shown, it emerged out of a context in which understandings and practices related to childbirth and the provision of maternity care underwent a significant change.

Through doctors' efforts to extend their professional jurisdiction and the Health Department's strategies to combat maternal mortality, childbirth came to be seen as a process most safely managed within a hospital. This shift from home to hospital birthing need not in itself have led to the medicalisation of birthing practices because

midwives could have retained control over the services offered. However, in successfully promoting the idea of birth as pathology and improving their training and techniques, doctors secured control over how births were managed in hospitals (Fougere, 1994a: 154). Medical management of childbirth was supported by women's demands for access to the latest birthing techniques, which had come to mean the most effective pain relief.

Having accepted the medical argument for the advisability of childbirth in hospital, women's organisations put pressure on the state to pay the costs and provide the necessary ancillary services (Mein Smith, 1986: 119). Their demands for state provision of free hospital maternity care for all women were met by the Labour government's introduction of maternity benefits as part of its social security legislation in 1938. This benefit covered the full cost of general practitioner services related to pregnancy and childbirth and partial payment of specialist obstetric services. A separate benefit covered the full cost of homebirthing care provided by a domiciliary midwife.<sup>17</sup>

The introduction of the maternity benefit consolidated the doctors' position as the main provider of pregnancy and birthing care. By providing free medical and hospital services for maternity care, the state supported both the medicalisation of childbirth and the dominance of doctors over maternity work.<sup>18</sup> While some midwives continued to provide maternity care in private maternity hospitals and homes, they struggled to compete with general practitioner obstetricians. As Belgrave notes (1991: 23-24), trained midwives were prepared to accept subordination to the economic and

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<sup>17</sup> The domiciliary midwifery benefit reimbursed midwives who attended the mother at home at the birth and for 14 days afterward. These midwives had a contract with the local district office of the Department of Health but they operated as private practitioners. From 1971 until 1990 they were required to work under the supervision of a medical practitioner.

<sup>18</sup> The Social Security Act allowed a woman 'the doctor of her choice' and provided for delivery and postnatal stay at a public hospital: '... since benefits were paid for 14 days after the birth there was a growing tendency to equate this with 14 days free stay in hospital'. See MacKay (1983).

professional demands of medical practitioners for the sake of their own precarious professional status.

Maternity care continued to be dominated by the medical profession for the next five decades. Midwives retained the legal right to practice independently until the Nurses Act 1971, but very few worked in this capacity. Only 0.13 per cent of the births in 1971 (87 out of 63,986) were home births involving a domiciliary midwife and possibly a doctor (New Zealand Board of Health Maternity Services Committee, 1976: 44). Most women (92 per cent) had their babies in a public hospital with private, subsidised obstetric care provided by a general practitioner or specialist obstetrician. Midwives employed in hospitals provided obstetric nursing care under medical direction. An outspoken critic of this development in midwifery practice referred to midwives' role as that of the "obstetrician's handmaiden" (Donley, 1986: 49).

This remark is significant in that it reflects not only the diminished professional role of midwives but also the increasing influence of specialist obstetricians. While the majority of hospital births in the early 1970s involved general practitioners, obstetricians were endeavouring to assume a greater role. A report prepared by the Maternity Services Committee of the Board of Health in 1976 recommended that regional obstetric units be established to provide fully subsidised specialist obstetric and paediatric services.<sup>19</sup> These units were to cater for all "high risk cases" which, according to the report, amounted to half the patients. They would also manage a proportion of "normal" cases to provide undergraduate and postgraduate teaching for doctors and nurses (Maternity Services Committee of the Board of Health, 1976: 87).

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<sup>19</sup> This committee was formed in 1960 to advise the Minister of Health on all matters relating to the health of the pregnant woman and her child. Six of the 14 committee members responsible for the report, *Maternity Services in New Zealand*, were obstetrician/gynaecologists. The report resulted from a four year survey of maternity services throughout the country which was conducted by Professor Dennis Bonham, head of the postgraduate school of obstetrics and gynaecology, and Dr B.J. Mackay, of the Department of Health.

The establishment of high technology, specialist units and the declining birthrate led to the closure of many small maternity hospitals where care was predominantly provided by general practitioners. Closure of these hospitals meant that general practitioners who did not do home births had nowhere to deliver babies and therefore little incentive to pursue training in obstetrics (Donley, 1986: 117). Fewer general practitioners doing obstetrics meant fewer home births and more women receiving the services of an obstetrician to birth in hospital. Specialist obstetricians worked in both a private and a public capacity, deriving income from the maternity benefit and/or a charge to the patient.

### **3.4 Health sector initiatives in the 1980s**

By the early 1980s the public health system in Aotearoa/New Zealand, like its counterpart in countries such as Britain and Sweden, was showing signs of strain (Ashton, 1992, 1995; Beaglehole and Davis, 1992; Fougere, 1994b; Blank, 1994). Total health spending as a percentage of GDP had increased rapidly between 1970 and 1980 from 5.1 percent to 7.2 percent. While the health system was costing more, it was seen by many to be delivering less. As Fougere (1994b: 111) notes, there was considerable dissatisfaction among policy makers with health sector efficiency, with the responsiveness of services to users and with the balance between prevention, primary and secondary care. Fragmentation in the system meant that primary care, secondary care and public health services were funded and provided in different ways. Within the secondary sector, hospital expenditure was increasing but waiting lists were lengthening.

State actors responded to these problems in the health sector with a variety of cost containing strategies. In an effort to rationalise the delivery of public health services and

secondary health care in a geographical area, the government introduced area health boards (AHBs).<sup>20</sup> The role of these boards was to provide hospital services, public health services and some community services for the people of their region from a population-based global budget. Prior to their formation, responsibility for the delivery of secondary services lay with the various hospital boards and public health activities were carried out by the Department of Health. By creating one administrative body to plan and co-ordinate health services in the public, private and voluntary spheres, it was hoped that the duplication and fragmentation in the provision of services that was believed to exist under the hospital board system would be reduced (Davies, 1990: 377).

The reorganisation of hospital boards into AHBs provided the opportunity for exploring new ways of delivering services to make them more flexible and consumer-responsive.<sup>21</sup> Among the initiatives to emerge in the provision of maternity care was the introduction of a 'domino' midwifery service in the Northland area in 1989.<sup>22</sup> This followed a survey which indicated that 20 percent of the birthing population in the area wanted 'continuity of care' (Kilgour, 1990: 23). The service involved domiciliary midwives attending women antenatally and in early labour at home, providing (medically supervised) birth and early postnatal care in hospital and up to 14 days

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<sup>20</sup> The idea of creating regional health authorities that would be responsible for the coordination of all health services within their boundaries was first put forward by the Labour government in a White Paper entitled *A Health Service for New Zealand* (1974). This proposal was developed by the Special Advisory Committee on Health Services Organisation (SACHSO) which was set up in 1975 by the National government. The Area Health Boards Act, which was passed in 1983, provided for the merger of hospital boards and district offices of the Department of Health to form area health boards. This transition to AHBs could only take place on the motion of the locally elected hospital board. Between 1983-89 twenty seven hospital boards were restructured into fourteen AHBs. See discussion in Fougere (1984), Martin (1987), Hay (1989) and Bowie and Shirley (1994).

<sup>21</sup> According to Fougere (1988) the area health board framework placed an emphasis on community participation, better management and information systems coupled with an organisational mission that sought to inter-relate primary care, health development and hospital services.

<sup>22</sup> Two pilot schemes to trial the area health board format were introduced in Wellington (1979) and Northland (1978). These schemes operated alongside the existing health administration structures.

postnatal care at home. The midwifery services provided in the home were paid for by the Ministry of Health while the AHB paid for the hospital care.<sup>23</sup> Other alternatives developed by boards for "low risk" women included the establishment of birthing centres (special units within hospitals which provided a home-like environment for labour and birth) and community based midwifery care.

An analysis of the shortcomings in health policy by Treasury in 1984 identified "major deficiencies" related to the Government's role in the provision of health (The Treasury, 1984). Treasury analysts argued that the state's involvement in both the funding and provision of health care meant that there was not the scope for efficiency in service provision that was possible when services were devolved to providers who competed for delivery of services. Their recommendations included separating health funding from health provision, introducing competition between providers of services to ensure greater efficiency (more value for money) and greater emphasis on 'community health care' to ensure responsiveness by health care providers to consumer needs.

The Treasury report also drew attention to the problem of 'provider capture' in health. This concept referred to the situation where "those who supply state-provided services pursue their own interests at the expense of the interests of consumers" (Orr, 1997: 80). According to Treasury (1984: 272), the failure to shift resources to areas of higher potential benefits "may reflect the orientation of health services to the preferences of suppliers, rather than the preferences of their clients".<sup>24</sup> Treasury's concern with medical practitioners being able to pursue their interests at the expense of either

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<sup>23</sup> The Northland Area Health Board paid the two domiciliary midwives involved in the service, which was set up on a one year trial basis, \$16,340 for the hours of labour and birth attendance in hospital involved in the 70 domino births (McFarland, 1990). Of the 70 births, 65 were normal deliveries, three were ventouse assisted and two were by caesarean section. Helen Clark noted in a speech in 1990 that the three per cent rate for caesareans compared favourably with a national average of nine per cent and a hospital average of fourteen per cent.

<sup>24</sup> This concern about 'provider capture' of the AHBs was evident in a Treasury *Briefing to the Incoming Government* (1990) and will be discussed in chapter five.



consumers or other health care providers prompted it to question in 1987 (in relation to the maternity benefit schedule) whether it was the public or doctors who benefitted from the restrictions on midwifery practice contained in the Nurses Act 1977. Clearly, it saw restrictions on maternity practice as anti-competitive and an impediment to the provision of cost-effective services.

Treasury's arguments about the need to introduce "managed competition" into the health sector as a means of increasing efficiency and enhancing responsiveness to service users were consistent with changes being introduced by the fourth Labour Government into other parts of the public sector (Boston and Holland, 1987; Bollard and Buckle, 1987; Easton, 1987, 1997; Kelsey, 1995).<sup>25</sup> These changes included the introduction of private sector management and the transformation of government departments with commercial value into profit generating State-Owned Enterprises (SOEs). Important in these reforms were measures that streamlined and clarified the role of the Government as owner of each organisation from the management of each organisation (Scott, 1994).

Treasury's arguments were also similar to those being advanced in countries such as the United Kingdom and Sweden (Ham et al., 1990; Klein, 1995; Ham, 1997) whose health systems were also funded mainly out of taxation.<sup>26</sup> These health systems, like Aotearoa/New Zealand's, had traditionally been organised according to an integrated model which combined public finance with public ownership of hospitals and salaried

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<sup>25</sup> The fourth Labour government came into office in July 1984 following a snap election called by former Prime Minister Sir Robert Muldoon. The snap election led to a run on the New Zealand dollar (due to the possibility of a post-election devaluation) and by election day the country had virtually no foreign exchange reserves. So the in-coming government inherited a constitutional and economic crisis and was immediately involved in emergency discussions with Treasury advisers who had previously made public their opposition to the interventionist and protectionist economic tactics of the Muldoon administration. The circumstances of this crisis help to explain the "economic revolution" pursued by a Labour party with a strong socialist tradition.

<sup>26</sup> Proposals to create an 'internal market' in the National Health Service were developed by Enthoven (1985). Implementation of the reforms began in the United Kingdom in 1991.

employment of doctors and other health professionals. In this model, responsibility for both financing and managing services rested with health authorities and planning was the key tool for increasing efficiency and responsiveness. However, as concerns about the costs and inefficiencies of services mounted, politicians and policy makers in these countries considered shifting to a contract model with separation of the purchaser and provider roles.<sup>27</sup>

In Aotearoa/New Zealand this concept of 'managed competition' amongst contracted health care providers was developed in different ways in two ministerial reviews of funding of the health services. The first of these reviews, *Choices for Health Care* (Scott et al., 1986), examined the funding of primary services. It supported the continuation of a major role for the state in funding health care and recommended a tighter contractual relationship between general practitioners and the state as a means of cost containment. In the area of maternity care, it suggested various alternatives to a fully subsidised benefit (Scott et al., 1986: 120-121). These included contracting arrangements in which midwives could offer competing services for straightforward childbirth (this would require legislative changes) or "firms" of midwives and doctors tendering to provide a range of services.<sup>28</sup>

The second review, which examined the funding and provision of secondary health-care services, advocated a separation of the funder and provider roles. In its report,

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<sup>27</sup> The introduction of this model for funding and providing health care generally, and maternity care in particular, is discussed in chapter five.

<sup>28</sup> The report also noted that domiciliary midwives were paid on a fee-for-service schedule which was amended in 1986 after considerable lobbying from user groups. Before the increase, it had been estimated that the average earnings of a domiciliary midwife were about half that of a hospital midwife for similar working hours and many more hours on call. The rate increased by 50 percent but domiciliary midwives were still lowly paid by comparison (Scott et al., 1986: 55). According to the amended schedule, domiciliary midwives could claim \$13 for an antenatal consultation (maximum of 3), \$75 for a delivery and \$13 per post-natal visit (maximum of 12 within 14 days). By contrast, general practitioners could claim \$26.50 for an initial consultation, \$13.25 per ordinary antenatal consultation (maximum of 14), \$185 for labour and delivery and \$13.25 for postnatal consultations (maximum of 4).

*Unshackling the Hospitals*, the taskforce advocated the retention of AHBs as providers to be paid for the services they delivered, but interposed a National Health Commission and regional health authorities as funders (Gibbs et al., 1988).<sup>29</sup> These regional health authorities would contract with providers, from the public or private sector, on a "competitively neutral basis" and would award contracts "according to quality and value for money" (1988: 27). The taskforce argued that this purchaser/provider separation would lead to more efficient provision of services by containing costs through competition between alternative providers.<sup>30</sup>

Due largely to opposition from the medical profession, the recommendations from these reviews were not immediately acted upon by the Government. As Minister of Health after the 1987 general election, David Caygill identified such issues as the "diffusion of responsibility, the lack of co-ordination of policy making and the absence of community input" as key problems in the health service. His solutions, published in *Health: A Prescription for Change* (1988a), included the requirement that individual AHBs negotiate budgets and performance criteria with central government and the devolution of responsibility for primary health care funding to boards.<sup>31</sup> The latter proposal was controversial because it involved the delegation to AHBs of responsibility for spending funds previously committed to the payment of social security benefits (Martin, 1987). The rationale was that AHBs would then have the flexibility to respond to a diversity of primary health care issues.

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<sup>29</sup> This controversial report was more popularly known as the Gibbs Report because the taskforce was chaired by prominent businessman and New Zealand Roundtable member, Alan Gibbs.

<sup>30</sup> Evidence of inefficiencies in the provision of public hospital services was produced in the *Hospital Performance Assessment Review* (1987) which was commissioned by the taskforce. This report, which was prepared by a Chicago-based accounting firm called Arthur Anderson and Co., argued that hospital costs could be reduced by up to 32 percent without reduction in output. This figure was disputed by various analysts (eg. Easton, 1987a; Fougere, 1988) who criticised its methodology. Treasury (1990: 119) estimated that cost savings in the order of 10-15 percent could be achieved without impairing the level of service.

<sup>31</sup> This was also the year that general management was introduced into the AHBs, replacing management by doctor, nurse and administrator.

Alongside these discussions about major health sector reform were policy documents supporting changes in the delivery of childbirth services. For example, the report of the Women's Health Committee to the Board of Health (1988: 31) recognised that there were limited options for birthing choices. It stated:

A particular concern centred around the provision of choice and alternatives in the birth process. Both flexible hospital arrangements and a viable home birth service were sought. The role of the midwife, and in particular the domiciliary midwife, was believed to be central.

Another important report, prepared by the Working Group for Safe Options for Low Risk Pregnancy for the Department of Health (1989), stated that pregnancy was a natural physiological event which, in the majority of cases, would have a normal outcome.<sup>32</sup> It recommended that the department:

- fund a pilot programme to establish the cost of continuity of care
- involve consumers in the development of board contracts and performance indicators
- review the benefit structure for domiciliary midwives to ensure that women who chose a homebirth had access to the same services that medical practitioners provided free of charge
- support direct entry midwifery training

The working group also made a number of recommendations for implementation at AHB level (1989: 8-9). These included:

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<sup>32</sup> This working group included representatives from Pacifica, Parents Centre, Home Birth Associations, NZCOM, Wellington Maternity Action, Domiciliary Midwives Association, Maori Women's Welfare League, RNZCGP, RNZCOG, Auckland Women's Health Council and the Department of Health. The report was the outcome of two years of consultation.

- the introduction of the domino maternity option in which care before and after the birth is provided outside the hospital (with planned early discharge)
- the provision of up to 10 days postnatal midwifery care
- the appointment of a senior advisor on women's health and greater involvement of women (at least half the membership) on all board committees
- the provision of "acceptable" facilities for normal births eg. family rooms
- the revision of existing policies on access to beds to ensure that barriers to choice of location and choice of health professional were removed.

These recommendations reflected the growing pressure from various groups of maternity consumers/activists and health professionals for women to have more information and choice in all aspects of childbirth. Since the late 1970s there had been mounting criticism, both internationally (Ehrenreich and English, 1979; Oakley, 1980, 1984) and in Aotearoa/New Zealand (Donley, 1986), about the management of childbirth in hospitals. Of central concern to those involved in the women's health and home birth movements was the medical profession's power to 'medicalise', and thereby control, aspects of human experience including childbirth.<sup>33</sup> In the area of childbirth, medicalisation was seen as responsible for redefining the natural process of childbearing as unnatural and introducing unnecessary technological interventions which increased, rather than reduced, the risks to mother and/or baby.

At the forefront of consumer organised opposition to hospitalised/medicalised childbirth in Aotearoa/New Zealand was the Home Birth Association (HBA) which began in Auckland in 1978. The HBA was formed by parents who chose home births to support the few domiciliary midwives and general practitioners who offered this birthing option (Donley, 1986, 1992). As well as organising antenatal classes for those choosing to birth at home, HBA members lobbied the Department of Health to improve midwives'

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<sup>33</sup> See Bunkle (1994) for a discussion of the various forms of feminist thought and activity that constitute the broad coalition identified as the women's health movement.

pay and conditions. While the total number of home births occurring each year was low, the HBA quickly became a political force to be reckoned with.<sup>34</sup> Branches developed throughout the country and the first national conference was held in 1980. High profile domiciliary midwife and activist Joan Donley (1992: 1) recalled the early days of HBA activity:

Amidst breast feeding babies, coping with toddlers, cooking meals, washing nappies (no environmentally unfriendly disposables in those days) they attended meetings and seminars, planned strategies, wrote letters and submissions among the crumbs on the kitchen table, churned out newsletters on ancient gestetners, lobbied MPs and became a politically strong 'vociferous minority'.

An important goal that midwives and women within the home birth movement shared was that of professional autonomy for midwifery (Tully et al., 1998). The requirement for medical supervision of all births meant limited access to home birthing in areas where doctors were unwilling to provide such care. It also impinged on the close relationships being formed between domiciliary midwives and their clients. By the early 1980s it was clear that midwifery autonomy was the only way to ensure the provision of home birth services to women and their families. Members of the HBA in Auckland set up a separate maternity action group, called Save the Midwives, in 1983 to spearhead the campaign for midwifery autonomy. This group was also concerned with lobbying for the introduction of direct entry midwifery (DEM) training.<sup>35</sup>

The home birth associations and Save the Midwives were not midwifery's only consumer supporters. Other groups such as Parents' Centre had been lobbying for years for midwifery as an alternative choice of care for women in childbirth (Dobbie,

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<sup>34</sup> There was a small but steady increase in the number of home births throughout the country between 1984 and 1988. Auckland Home Birth Association figures (Abel, 1997: 75) show that they totalled 369 in 1984, 387 in 1985, 542 in 1986, 596 in 1987 and 680 in 1988.

<sup>35</sup> See chapter four for discussion of consumer involvement in the campaign for midwifery autonomy and DEM training.

1990). The political activities of these various groups throughout the 1980s were important in raising the public profile of midwifery as a profession specialising in the provision of normal maternity care. This well-organised and highly vocal consumer/client support was influential not only in challenging the medical profession's legal monopoly over the provision of maternity services but also in promoting midwifery as a more cost-effective and consumer-oriented form of maternity care.

The argument for increasing the choices available to the consumers/users of maternity services was supported by the Department of Health. In a report to the Minister of Health in May 1989, the chief nursing officer stated that support should be given to the midwives' campaign for professional autonomy in order to provide women with the birthing services they requested. The department was aware of instances where women who did not have access to a domiciliary midwife were choosing to have a home birth without professional support. There was concern that the incidents could become more prevalent as women "continued to challenge their right to childbirth choices" (Smail, 1989: 5).

The report stated that hospital and AHBs had a responsibility to ensure that women's choices were acknowledged and that their decisions would not compromise their well-being or that of their infants. According to the department, if women chose to have their babies at home then hospital/area health boards had a responsibility to make that option as safe as possible. In taking this stance, the department was using an argument about safety in childbirth to support midwifery autonomy and an increased range of choices in maternity services. This was a shift away from an earlier position in which the department opposed greater autonomy for midwives because it believed there were insufficient safeguards to ensure safety in domiciliary practice.<sup>36</sup> It is an example of

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<sup>36</sup> A memorandum to the Cabinet Social Equity Committee from the department in 1988 advised that the restrictions on domiciliary midwifery practice should not be removed until new systems which ensured the "continuity for safety" in homebirth be established. It noted that hospital and area health boards had systems in place to ensure the safety of

how similar arguments about issues such as 'safety' can be used in an effort to secure significantly different political ends.

The department's support for midwifery autonomy was influenced by Helen Clark who became Minister of Health in February 1989.<sup>37</sup> She considered the loss of autonomy for midwifery to be an "injustice" and initiated an investigation into how a change in the law might be made. In a speech to members of the NZCOM in August 1990, she said she had discovered "surprising allies" in the campaign for midwifery autonomy.

Even the Treasury could see merit in increased autonomy. And if we look at the problem from the perspective of those officials who have been charged by government with reviewing restrictions on practice which are in essence anti-competitive, there is certainly a strong argument to be mounted against the monopoly of registered medical practitioners in taking full responsibility for the supervision of childbirth (Clark, 1990: 2-3).

Clark saw midwives playing a very important part in the primary health care services which she regarded as being of central importance in the country's overall health policies.

Midwives can have a special relationship with mother and child. You are in the ideal position to convey important primary health care messages, such as the importance of vaccination. You should be part of developing strategies with area health boards which can lower the incidence of low birth weight and premature babies (Clark, 1990: 9).

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mother and infant which doctors became part of when they signed contracts to provide childbirth services. However, midwives had a contract with the Minister of Health for payment of the maternity benefits only. According to the memorandum, the midwives' contract did not cover the maintenance of skills in delivering babies safely (there was no minimum number of deliveries necessary to permit continued practice), nor did it cover access to hospital obstetric and emergency services or include mechanisms for reviewing and monitoring the safety of the services provided (Caygill, 1988b: 2).

<sup>37</sup> It was indicative of Clark's influence in the Labour Party that she was also appointed deputy Prime Minister in August 1989, thus becoming the highest ranking Minister of Health in recent history (Beaglehole and Davis, 1992).



This interest in the role that midwives could play as autonomous health professionals in the primary health care arena was consistent with other initiatives that Clark promoted to increase accountability and contain expenditure within this sector of the health services.<sup>38</sup> She had expedited the formation of AHBs and initiated work on the development of Aotearoa/New Zealand's first set of health goals and targets (Beaglehole and Davis, 1992; Bowie and Shirley, 1994). These goals and targets were to be the focus of the annual contract between the Minister of Health (the primary funder of health care) and the AHBs (the primary providers of health care). The ten national goals reflected growing concern about the extent to which illness and disease were related to lifestyle factors such as smoking, poor nutrition and inadequate exercise.<sup>39</sup>

The Minister's concern with the role played by primary care practitioners in health prevention and promotion was in line with general criticism about both the increasing cost, and the inappropriateness, of some forms of institutionalised health care. This criticism, which came from various sectors of the community, focussed particularly on the cost of secondary services and the disempowerment of service users (Cheyne et al., 1997: 226). Submissions to the review on primary services had expressed dissatisfaction with large bureaucracies that seemed "distant and unresponsive" and demanded systems that took account of, and reacted to, the needs of local communities.

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<sup>38</sup> In 1989 Clark released a report/policy statement entitled *A New Relationship: Introducing the New Interface Between the Government and the Public Health Sector* which focussed on the relationship between the AHBs and the government. This introduced a contract between the Minister and the chairperson of a board which would identify operating and strategic plans, funding levels and the defined obligations of both parties.

<sup>39</sup> The national health goals, which were released in December 1989, were: to reduce the number of smokers and the consumption of tobacco, to reduce the incidence of dietary-related health disorders by improving nutrition, to reduce alcohol-related health problems by reducing alcohol consumption, to reduce the prevalence of high blood pressure and to reduce preventable death and disability from motor vehicle accidents, to reduce hearing loss in children under five years of age, to reduce disability and death from asthma, to reduce avoidable illness and death from coronary heart disease and stroke, to reduce the incidence of invasive cervical cancer and the cervical cancer death rate and the reduce skin cancer (melanoma) incidence and death rates. For discussion see Beaglehole and Davis (1992).

The review team noted a slowly growing dissatisfaction with the idea that more drugs, more technology and more hospitals would solve the problems of the country's health (Scott et al., 1986: 2).

Associated with these criticisms was concern about the increasing medicalisation of society. The argument was that too much individual power and responsibility had been given up to the medical profession with the result that some people had become overly dependent on the opinions of health care "experts". Such arguments and criticisms were described as "powerful" by the review team because they led to a search for experiment and innovation and encouraged diversity. It endorsed such an approach and stated:

... attention given to local community involvement, decentralisation of power and more consumer influence may mean that solutions more closely match problems (Scott et al., 1986: 2).

Public concern about both the increasing influence and the lack of accountability of the medical profession, especially in relation to women's health care, was heightened in 1987 with the judicial inquiry into the "unfortunate experiment" at National Women's Hospital in Auckland (Coney and Bunkle, 1987; Bunkle, 1988; Coney, 1988, 1993; Cartwright, 1988; Davis, 1988). This inquiry investigated the conservative treatment over 20 years of a number of women with carcinoma in situ or cervical cancer (CIS) by a hospital specialist, Professor Herbert Green. The 'experiment' involved following women with CIS without treating them to eliminate the disease. Its purpose was to attempt to demonstrate that CIS did not lead to invasive cervical cancer.

District Court judge Silvia Cartwright found that there had been a failure to adequately treat a number of patients which had resulted in persistence of the disease and, in some cases, death (Cartwright, 1988). She recommended the disbandment of the ethical committee at the hospital, the introduction of treatment protocols and procedures for

research and major institutional changes in the area of patient rights, including a patient advocate and a health commissioner (Davis, 1988: 248).<sup>40</sup> She also recommended the establishment of a national cervical cancer screening programme. As a consequence of this inquiry, not only was there greater concern with the rights and needs of the health consumer but also increasing disillusionment with aspects of medical practice. As Corbett (1989: 72) commented:

As a result of the Cartwright Inquiry both doctors and patients have changed. Patients are now less trusting of their doctors, and doctors have become more willing to listen to their patients. The emphasis has gone onto the health consumer (1989: 72).<sup>41</sup>

While the events involved in the 'unfortunate experiment' and its aftermath were specific to Aotearoa/New Zealand, challenges to the autonomy and expertise of the medical profession were occurring internationally (Starr, 1982; McKinlay and Stoeckle, 1988).<sup>42</sup> Writing in the British context, Kelleher et al. (1994: xiii) described doctors as having become "increasingly embattled as their position as experts has been challenged from inside and outside the health arena". They identified these challenges as coming from new management structures (introduced in the National Health Service reforms), the professionalising strategies of allied health occupations, the growth of interest in 'complementary' or 'alternative' medicine and self-help groups and feminist opposition to the hegemony of the biomedical model.

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<sup>40</sup> The New Zealand Bill of Rights Act, which guarantees the right to personal autonomy (including the right to refuse to undergo medical treatment), was passed in 1990. The Health and Disability Commissioner Act 1994 established the Code of Health and Disability Consumer's Rights. Rights 5, 6 and 7 of this code interact to form the nucleus of the doctrine of informed consent. See Pearce (1998) and Burgess (1996) for discussion of these rights in relation to midwifery practice.

<sup>41</sup> This Metro article revisited aspects of the original 'unfortunate experiment' investigation and alleged that it was the outcome of a feminist/Labour Party conspiracy. It described the judicial inquiry as a "radical feminist witchhunt". Regardless of the accuracy of these claims, they point to the influence that feminist health/political activists were seen to have with the Labour government in the late 1980s.

<sup>42</sup> This point relates back to the discussion in chapter two of the debate over the decline of the medical profession through proletarianisation or deprofessionalisation.

Of significance for maternity activists and midwives in Aotearoa/New Zealand was the recognition that the 1980s had seen not only the end of an era of optimism about scientific medicine but also, not unconnectedly, the "end of the era of the passive patient" and the beginning of an era of active "consumerism" (Stevens, 1986: 76). Associated with this shift towards greater emphasis on holism and patient participation was a vigorous neo-liberal challenge to professional monopoly as inhibiting informed consumer choice (Elston, 1991; Alaszewski, 1995). In countries such as the UK, radical proposals to curtail restrictive professional practices in the name of "consumer power" emanated from right-wing think tanks and statutory agencies. This neo-liberal perspective focussed on the efficient delivery and financing of health services and on issues of consumer choice (Ranade, 1994).<sup>43</sup>

Arguments informed by this perspective were evident in the case Helen Clark put forward in parliament for midwifery autonomy. She argued that midwives would provide women with choices and alternatives in the birth process and that their expertise and skill would enable maternity services to become more flexible and consumer-oriented. She spoke about costly and inappropriate forms of medical intervention being used in normal or 'low risk' pregnancies and the likelihood of costs being lowered because "the midwife is not using the whole range of technology that a medical practitioner might be tempted to use when attending a birth" (New Zealand Parliamentary Debates, 1989: 13485). Perhaps the most telling evidence of the strength of her economic arguments was the support given by Treasury for midwifery autonomy.

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<sup>43</sup> See chapter five for discussion of how this New Right approach to health sector reform was actioned by a National-led government in Aotearoa/New Zealand in the 1990s.

### **3.5 Expertise and the state**

This account of how jurisdiction over the provision of maternity care came to be dominated by doctors in the 1930s, and shared with midwives in the 1990s, highlights the contingency of professional autonomy. It provides an example of how professional autonomy, like other forms of jurisdiction over professional work, is not secured once and for all but requires constant reinforcement, renegotiation and re-establishment within the context of changing government policies and programmes (Abbott, 1988; Johnson, 1995: 21-22). Whatever success that professional groups have in staking claims over particular forms of 'expert' work is likely to be partial and subject to further contestation. Thus autonomy is the outcome of a political process involving dynamic and changing relations between various groups of state, practitioner and public actors.

Of particular significance for an occupation's professional status is its relations with the state. As the discussion in this chapter highlights, the state has played a crucial role in constituting, reproducing or diminishing the jurisdiction that general practitioners and midwives have had over the provision of maternity services throughout this century. Through legislation governing the regulation and funding of maternity services, state actors have supported different professional claims over the provision of autonomous birthing care depending on broader health policy concerns. This analysis therefore supports arguments identified in the previous chapter (eg. Torstendahl, 1990a; Burrage, 1990; Johnson, 1993, 1995) about the need to recognise the role the state plays in shaping the work available for professions and the outcomes of professional struggles.

This chapter has shown how the part played by state actors in shaping professional control over the management of maternity care in Aotearoa/New Zealand in the 1930s

and 1980s has been influenced by their interests in achieving a range of health policy objectives. It was a determination to provide increased access to health services generally, and to free them from a reliance on funding from patients, that prompted state actors in the 1930s to introduce the social security legislation and the maternity benefit. While the introduction of fully subsidised maternity care gave all women access to free childbirth services, it also consolidated doctors' control over where and how childbirth was managed. The outcome of this legislation was to authorise medical 'expertise' as the most appropriate form of professional maternity care. In doing so, it effectively confirmed midwives' loss of professional autonomy.

By contrast, the interest state actors had in the late 1980s in containing costs, increasing consumer choice and diminishing professional control within the health sector, led them to support legislation which recognised midwives as having the necessary 'expertise' to provide independent birthing care. Arguments from groups of consumers and midwives about the ways in which an autonomous midwifery service would be more cost-effective than medicalised maternity care, and how it would offer increased choices for women, were effective in a context in which politicians and policy-makers were looking to establish more flexible, efficient, consumer-oriented health services. Out of a convergence of these interests came the opportunity for state actors to not only respond to consumer demands for a greater say in the way maternity services were provided, but also to introduce competition into the provision of those services.

In highlighting the role of the state in the changing professional fortunes of general practitioners and midwives, the intention is not to suggest that these jurisdictional arrangements were simply the outcome of the goal-oriented activities of state actors. Rather, that it is more useful to see the success or failure of professional strategies as being influenced by the ability of groups to link their interests and claims to broader social, economic and organisational changes. This argument is supported by a

conceptualisation of the state as a "weighty actor" which affects political and social processes through its policies and its patterned relationships with social groups (Evans et al., 1985; Tilly, 1995; Skocpol, 1992).<sup>44</sup> In arguing for "bringing the state back in" to analysis, Skocpol (1985: 21) claims that states "matter":

... because their organisational configurations, along with their overall patterns of activity, affect political culture, encourage some kinds of group formation and collective political actions (but not others), and make possible the raising of certain political issues (but not others).

The importance of the role of the state in establishing the political context (or culture) for professional claim-making can be seen in relation to the passing of the Nurses Amendment Act. In promoting primary health initiatives, women's health issues and greater personal responsibility for health care, the Labour Government created a political context/culture that was receptive to the concerns/demands being made by groups of midwives and maternity consumers/activists. The discourses of efficiency, accountability and consumer choice in health services, that were utilised by state actors in their attempts to contain and control health spending, were also drawn on by these groups in claiming legal autonomy for midwifery. This highlighted the compatibility between a midwifery model of maternity care, with its emphasis on a non-interventionist, client-focussed approach to childbirth, and the Government's health funding policies.

The granting of legal autonomy to midwives did not resolve the politics of childbirth in Aotearoa/New Zealand. In fact, this legislation was a catalyst for increasingly acrimonious relations between midwives and doctors. By giving both doctors and midwives legal jurisdiction over the provision of publicly-funded maternity services,

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<sup>44</sup> This concept of the state as an actor, which may formulate and pursue goals that are not simply reflective of the demands or interests of social groups, will be developed in chapter five in relation to the introduction of a new method of funding/providing primary maternity services despite intense opposition, particularly from the medical profession.

the state set the two professions up in competition with each other for clients. This competition ensured that claims and counterclaims over issues of expertise, safety and consumer choice continued to be aired regularly in the public and political arenas. Ongoing negotiations with the state over proposed changes to the funding and provision of maternity services, proved to be a key site for the playing out of this intense inter-professional rivalry.

An issue that will be highlighted in discussion of these negotiations between state actors and representatives from midwifery and medical organisations was the escalating cost of primary maternity services (see chapter five). Despite claims that midwifery autonomy would lead to savings in the cost of maternity care, there was a dramatic increase in the maternity budget between 1990 and 1994 (Muthumala and Howard, 1995). A fee-for-service funding system which facilitated the provision of shared care by general practitioners and midwives contributed significantly to this budget "blowout". As a consequence of increasing costs, and difficulties arising from midwives' and general practitioners' overlapping jurisdiction over childbirth, negotiations shifted to a fixed-fee funding system and the innovation of a lead maternity care provider (LMC) who effectively held the budget for a client's care. The implications of these changes are examined in chapters five to eight.

It was not only relations between medicine and midwifery that changed significantly as a consequence of the Nurses Amendment Act. The passing of this legislation also dramatically altered relations between midwifery and nursing. In giving midwifery autonomous status, the Act not only recognised midwifery and nursing as separate professions but also gave midwives, many of whom held nursing qualifications, access to opportunities for practice and financial reward that nurses had so far been denied.<sup>45</sup>

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<sup>45</sup> The government is currently reviewing the funding of nursing practice and considering whether nurses should be able to prescribe some medicines, claim drug subsidies and order laboratory tests.



Midwifery autonomy could have been of advantage to nursing if midwifery had remained an advanced career option for nurses. However, by facilitating the introduction of direct entry midwifery training, the Act played a critical role in enabling midwifery to consolidate an independent professional status. The significance of DEM training for (re)constituting midwives as autonomous birthing practitioners is examined in the next chapter.

## **Chapter Four**

### **Direct entry training: (Re)constituting midwives as independent birthing practitioners**

I felt that degree education was more appropriate for midwives who were going to be independent practitioners. If we were going to play the game of stacking ourselves up against another profession then we should have the equivalent qualification.

- Co-ordinator of Midwifery Degree course, Otago Polytechnic, 1993.

#### **4.1 Introduction**

An unexpected outcome of the Nurses Amendment Act 1990 was approval for the introduction of two pilot direct entry midwifery (DEM) courses. The introduction of DEM training was critical to midwifery consolidating its independent professional status in several ways. Firstly, it gave midwifery, rather than nursing, greater control over what midwives should know in order to practice and how they should acquire that knowledge. Secondly, it allowed midwifery educators and leaders to not only (re)constitute midwifery as expertise in 'normal' pregnancy but also produce practitioners with the knowledge and skills to practise independently of doctors. Thirdly, it laid the basis for a nucleus of actors whose full-time work was to define or construct a midwifery 'discourse' or 'science'.

This chapter analyses the shift from midwifery as craft practice, to midwifery as 'specialist' nursing-based practice underpinned by a curative/medical discourse, to midwifery as 'specialist' maternity practice with its own knowledge base. While this practice is organised around a 'partnership' relationship between professional and

client/consumer, it is also informed by a body of relatively abstract knowledge which underpins the practical application of this learning. An interesting aspect of this case study is that the formalisation or codification of this knowledge base has taken place following the gaining of professional autonomy. Unlike professions which are pushed into theoretical elaboration of their knowledge base in competing for jurisdiction (Abbott, 1988), midwifery embarked on this process after securing the legal right to independent practice. It therefore provides an opportunity to examine how jurisdiction indirectly shapes professional knowledge.

In analysing the introduction of DEM at Otago Polytechnic, this chapter highlights the importance for a profession of having control over its training so it can produce practitioners with a particular package of knowledge and skills which enables them to provide a distinctive form of professional or expert service. As Larson argued (1977), it is important for a profession that its practitioners provide this service in such a way that it is recognisable to the public/consumers as being underpinned by a shared expertise. For midwifery it is important that midwives be trained to provide a service that is different from that provided by other health professionals, particularly doctors, and involves the exercise of expert judgement (Brain, 1991). Hence the partnership model with its emphasis on normal pregnancy, as defined on a case-by-case basis, and continuity of midwifery care.

## **4.2 From midwife to obstetric nurse**

Legal definitions of what it means to be a midwife have changed significantly throughout this century as various laws and regulations have redefined their training and scope of practice. While legal definitions are only one aspect of midwives' complexly constructed professional identities, they are obviously important in determining who is entitled to claim the title 'midwife' and is authorised by the state to

provide particular maternity services. Through legislation governing the qualifications and practice of midwives and nurses, the state has at various times constituted midwives as either independent maternity care providers or maternity/obstetric nurses whose practice is supervised by the medical profession.

The first legislation governing the training and practice of midwives in Aotearoa/New Zealand was the Midwives Registration Act 1904.<sup>1</sup> This Act distinguished between those practitioners who had no formal training but more than three years experience, who were categorised as class B midwives, and those trained at a St Helens Hospital or a recognised school of nursing overseas. Both these groups of midwives could work independently of doctors, providing care to women having normal labours. Untrained women who had less than three years midwifery experience were categorised as maternity nurses and were required to work under the supervision of a medical practitioner. According to Mein Smith (1986:16-17), most class B midwives chose to work as maternity nurses like their unregistered equivalents. This was no doubt due to their precarious status in relation to the increasing influence of general practitioner obstetricians (Belgrave, 1991: 24).

Early in the twentieth century the distinction was made in law between a midwife, who could provide independent care to a woman with a "normal confinement", and a maternity nurse who had to work under medical supervision. Midwifery skill was becoming defined in terms of qualifications and access to formal training rather than experience. Like nursing, midwifery had an interest in improving its precarious social and economic status within the emerging health care division of labour through formalised training and licencing. According to Belgrave (1991: 24), both occupational groups sought to emulate the medical profession by creating social and professional

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<sup>1</sup> The registration of both midwives and nurses (the Nurses Registration Act was passed in 1901) was promoted by Grace Neill, the Assistant Inspector of Hospitals between 1895 and 1906. She was instrumental in setting up the St Helens hospitals to provide care for the wives of working men and training for midwives. See Donley (1986: 30).

barriers around their work. By forging a link between education and occupational licencing, they sought to not only improve their standards of training but also restrict access to their ranks.

While these moves towards a formal, education-based professional status improved the social position of nursing and midwifery, it also brought them increasingly under the control of medicine. Belgrave stated (1991: 24) that both groups were prepared to accept subordination to medicine in order to share its growing professional status. In a context where doctors were consolidating their position at the top of the health care division of labour, these female-dominated occupational groups had little choice but to define themselves through their relationship to scientific medicine. However, a consequence of this professional subordination was that their training and practice came to be increasingly medicalised. Not only did this give doctors greater authority over the tasks performed by nurses and midwives, but these tasks or skills came increasingly to be seen as belonging to one occupational group ie. nursing.

An important factor contributing to the collapse of an occupational distinction between nursing and midwifery practice was the shift from home to hospital birthing (as discussed in chapter three). As childbirth came to be regarded as a pathological event most safely managed in hospitals by doctors, the role of midwives as independent maternity care providers both in hospitals and the community was diminished (Mein Smith, 1986; Donley, 1986; Papps and Olssen, 1997). As noted previously, an important factor that enabled doctors to secure control over how births were managed in hospitals was their use of chloroform and other surgical interventions. These procedures involved hospital staff working in teams with the midwife's role becoming that of a nursing assistant to the medical practitioner (Donley, 1986: 41; Parkes, 1991)

This redefinition of midwifery as a specialised form of nursing practice was evident in 1925 when the Nurses and Midwives Registration Act raised midwifery training to post-graduate status.<sup>2</sup> While this legislation aimed to raise the level of midwifery training and thus the status of midwives, it reclassified the majority of practising midwives as maternity nurses. As Mein Smith explained (1986: 37):

The 1925 Act was considered controversial at the time because it purported to raise the status of midwives, but only the new category of midwives subsequently benefitted. Those already in practice were reclassified as maternity nurses, and were therefore assigned a lesser status.

Not only did this Act reduce the number of practising midwives at a time when the profession's position vis a vis medicine was precarious, but it also gave nurses more opportunity to work in the area of maternity care. It did this by creating a new nursing registration, that of maternity nurse, which was available to qualified nurses who completed a six-month maternity nursing course (Burgess, 1984: 61-62). Unqualified women, ie. non-nurses, could be registered as maternity nurses after an 18-month course. Both groups could qualify as midwives after a further six months of midwifery training. So while the legislation aimed to enhance the status of midwives, it also encouraged women who wanted to be midwives to initially train as nurses.<sup>3</sup> This reflects the rise in the nursing profession's status during the 1920s (Mein Smith, 1986: 37).

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<sup>2</sup> The Act also created a registration board responsible for nursing and midwifery education. Membership of this board consisted of the Director-General of Health, the director of the division of nursing in the Department of Health, a registered medical practitioner (who was appointed by the Minister of Health), a registered nurse and a registered midwife. The nurse and midwife were appointed on the recommendation of the New Zealand Trained Nurses' Association or another association or society approved by the Minister of Health. See Papps and Olssen (1997).

<sup>3</sup> This emphasis on the value of nursing training as preparation for midwifery is shown by the changing use of the term 'untrained woman'. Mein Smith notes (1986: 37) that from the mid-1920s this term, which had previously applied to unqualified but experienced women who practised as midwives, or more often as maternity nurses, was used to describe registered maternity nurses or midwives who had not completed their general nursing training.

In becoming more closely aligned with nursing, midwifery not only began to lose its status as a separate profession but it also became influenced by the gendered and hierarchical relations that existed between nurses and doctors.<sup>4</sup> Belgrave noted (1991: 21) that the inculcation of attitudes of discipline and obedience was an important aspect of nursing training. Nurses were encouraged to accept orders with military precision and analogies between nursing and military service were commonplace. However, while this incorporation within nursing meant midwifery practice came increasingly under medical control, there was the advantage of belonging to a larger and more organised professional group. Midwives were able to join the New Zealand Trained Nurses' Association which had been formed in 1909 to represent the interests of nurses throughout the country (Donley, 1986: 95; Burgess, 1984: 17).<sup>5</sup>

The inclusion of maternity training within a general nursing programme in the 1950s has been described as the move that finally subsumed midwifery into the nursing profession (Donley, 1986: 99). This change in the nursing curriculum meant that every general nurse had a 10-week maternity/obstetric nursing component incorporated into her/his three-year programme. Registered general nurses were eligible to undertake a six-month midwifery course offered at St Helens hospital. The maternity nursing programme, which had provided the means for non-nurses ie. direct entry trainees to become midwives, was gradually phased out. As Donley noted (1986: 99), this programme provided the last tenuous link with midwifery as a separate profession.

The incorporation of midwifery within nursing was legally formalised in the Nurses Act 1971. Not only did this legislation, as its name suggests, include registered

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<sup>4</sup> See Willis (1983) for a discussion of how the medical profession in Australia secured dominance over midwifery in a similar way.

<sup>5</sup> The issue of midwives being numerically a much smaller group than nurses, and arguably not having a national organisation to represent their interests prior to the formation of the NZCOM in 1989, is discussed in chapter five.

midwives in the same category as registered nurses but it also removed their legal right to practise independently.<sup>6</sup> Midwives, like maternity nurses before them, were now required to work under the supervision of a medical practitioner. In legally defining the work that midwives and maternity nurses did as "obstetric nursing", this Act effectively ratified the status quo whereby the majority of midwives worked in hospitals as specialist nurses under the supervision of obstetricians. It was only the handful of domiciliary midwives providing home birth maternity care who were working independently of the medical profession.

### 4.3 Nursing's professional aspirations

In the early 1970s nursing in Aotearoa/New Zealand was looking to improve its professional status through major changes in both the location and content of its training (Burgess, 1984; Christensen, 1990). A key concern was to get nursing training out of the hospitals and into tertiary-level educational institutions. According to Burgess (1984:64), there was a realisation by many in the profession that hospital-based nursing education programmes, with their focus on illness, were no longer the most appropriate method of preparing nurses for the future. She described nursing as beginning to feel "isolated" because all the other major health professional groups were located either in universities or technical institutes.

A catalyst for achieving change in nursing education was the publication of a report entitled *An Improved System of Nursing Education for New Zealand* (1971). Written by a Canadian director of nursing and WHO consultant, Dr Helen Carpenter, this report recommended moving basic programmes from hospitals to educational settings, reducing the number of schools of nursing, introducing university courses for nurses

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<sup>6</sup>According to the Act, a 'nurse' or 'registered nurse' included a registered community nurse, a registered general nurse, a registered male nurse, a registered maternity nurse, a registered midwife, a registered psychiatric nurse and a registered psychopaedic nurse.



and improving the career structure for nursing tutors. These recommendations were consistent with strategies being adopted by nursing leaders in the United States and Britain to enhance nurses' professional status (Carpenter, 1993; Salvage, 1992; Davies, 1995; Walby and Greenwell, 1994; Witz, 1994). These strategies aimed at turning 'clinical' nursing into an exclusive occupation by redefining it as intellectual rather than manual labour and, in the process, redefining the position of clinical nursing within the health-care division of labour.

An important aspect of this phase of professionalising activity was the development of 'new' nursing models and philosophies which promoted a more independent role for nurses vis a vis doctors in the delivery of patient care. Improved education was seen as the key to producing nurses who were "knowledgeable doers", able to marshal information to make an assessment of need, devise a plan of care and implement, monitor and evaluate it (Witz, 1994: 29). Central to this education for autonomous practice was the development of a new knowledge base which was independent of medicine and other health-care professions (Carpenter, 1993: 122).<sup>7</sup> This body of relatively abstract nursing knowledge was to provide practitioners with a systematic, problem-solving approach to patient care. This approach would involve nurses exercising professional judgements rather than carrying out routine, doctor-directed tasks.

By 1976 there were four technical institute schools of nursing in Aotearoa/New Zealand providing three-year comprehensive nursing programmes (Burgess, 1984: 66).<sup>8</sup> In line with Carpenter's recommendations, the St Helens Hospital midwifery programmes

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<sup>7</sup> This point links to the discussion in chapter two about the importance of professional groups having a knowledge base from which claims to expertise and autonomous practice can be made.

<sup>8</sup> According to Christensen (1990: 9): "In these new nursing schools, curricula used the available conceptual frameworks to provide graduates with the knowledge and skills required for a working life of hands-on nursing. Initially nurse educators combined wisdom borne of experience with creativity until the new curricula could be confirmed or rejected by systematic study".

were phased out and midwifery was incorporated in the advanced diploma of nursing (ADN) as child and maternal health nursing. The phasing out of hospital-based midwifery training in favour of this post-graduate diploma can be seen as an example of the changing emphasis in nursing training. Instead of focusing on practical, skills-based training in the hospital setting, nursing was looking to enhance its professional status through more theoretically-based training in advanced academic settings. By giving nursing practice a more theoretically-informed knowledge base, it was hoped that the foundation would be laid for claims to greater practitioner autonomy.

Ironically, it was the lack of clinical content in the ADN course that contributed to midwifery's opposition to the qualification. Statistics published by the Nursing Council (1985) showed that in 1984, just over 80 per cent of the 144 midwives who registered in Aotearoa/New Zealand had qualified overseas and a third of these were Aotearoa/New Zealand registered nurses. In the same year, only 27 nurses went on to do the ADN (Nursing Council of New Zealand, 1985). In 1980, the midwives' section of the New Zealand Nurses' Association (NZNA) had petitioned the then Minister of Education, Merv Wellington, to provide a separate, basic one-year midwifery course leading to registration.<sup>9</sup> The midwives expressed concern about the scant clinical content of the postgraduate midwifery course and the inconsistency between teaching in the classroom and practice on the wards (Donley, 1986: 104).

In attempting to get midwifery training reinstated as the basis for their registration, these midwives within the NZNA were beginning to challenge the view that midwifery belonged within the nursing profession.<sup>10</sup> Not surprisingly, nursing leaders opposed

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<sup>9</sup> In the mid 1980s there were approximately 600 midwives and 20,000 nurses in the New Zealand Nurses' Association. The midwives belonged to the Midwives and Obstetrical Nurses Special Interest Section of the association.

<sup>10</sup> In a paper presented at the Vision 2000 conference in Auckland midwifery leaders (Guilliland and Pairman, 1991) stated that midwifery as a 12 week clinical option within the Advanced Diploma of Nursing was never accepted by the midwifery profession and proved to be a less than ideal forum for recruitment and retention of a self-sustaining midwifery workforce.

the argument that midwifery and nursing should be separated. An NZNA policy statement on *Maternal and Infant Nursing*, released in 1981, defined a midwife as "a nurse who by reason of her advanced educational preparation, knowledge and skills, is qualified to care for women during pregnancy, delivery and the post-natal period, and for the fetus and the neonate". The association stated that midwifery was a post-basic qualification - "in that the nurse utilises the nursing concepts learned during the basic nursing programme and builds on these, at the same time acquiring new skills and knowledge relating to the practice of midwifery".

The NZNA's determination to retain midwifery as a 'specialist' career option was in keeping both with strategies being adopted internationally in relation to nursing professionalism and recommendations made by Carpenter (1971) about strengthening post-basic education for nurses in Aotearoa/New Zealand. According to Papps (1992), the association's assertion that midwifery was a post-basic nursing qualification was consistent with the policy it adopted in 1976 concerning post-basic education.

In this policy post-basic education programmes were linked with the concept of a career path, and to become a 'nurse practitioner' within this proposed structure, there was a requirement to have successfully completed an advanced diploma. This included, for those wishing to become midwives, an advanced diploma in one of the major clinical areas, for example, maternal and child health nursing (Papps, 1992: 53).

Any possibility of midwifery reasserting itself as an independent profession appeared to be lost when the Nurses Amendment Act 1983 allowed nurses who had not received midwifery training to provide maternity care, and prohibited direct entry midwives from doing home births. However, while this legislation appeared to consolidate the nursing profession's position vis a vis that of midwifery, it actually proved to be an important catalyst for a range of professional and political activities that contributed to the reconstruction of midwifery as a profession with greater control over its training and

practice. One important outcome was the emergence of collaborative relations not only between various groups of midwives, including those within the NZNA and those working in domiciliary practice, but also between these more politically active midwives and consumers involved with home birth and maternity action groups (see chapter three).

An indication of the degree to which some midwives were beginning to flex their professional muscle was their success, despite strong opposition from some nursing leaders, in getting both NZNA support and then ministerial approval for a separate one-year diploma of midwifery course.<sup>11</sup> Apart from arguing that midwifery and nursing should be seen as separate professions, the midwives could point to serious deficiencies in the existing midwifery training which meant that not only was there a shortage of midwives but many were going overseas to train (Donley, 1986: 103-104).<sup>12</sup> Their concerns about deficiencies in both the clinical and theoretical components of the ADN midwifery option were endorsed by a review of the ADN courses conducted by the Department of Education (1987).

While midwifery representatives had succeeded in obtaining a separate midwifery course there was on-going concern about the need to qualify initially as nurses. For

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<sup>11</sup> It is interesting to note the differing accounts of how this approval was gained. According to Papps (1997: 135), who was heavily involved in nursing politics in the 1980s, the midwives' section expressed concern in 1979 about the incorporation of midwifery education into a nursing diploma and argued for a separate midwifery course. She simply states that this was endorsed as a resolution of the NZNA at its 1980 annual conference, with a request that the Minister of Education make provision for such a course within the polytechnic system. Midwives' accounts of this time make reference to the obstructive tactics adopted by the national executive of the NZNA. For example, in 1984 it put a recommendation/remit to the national conference stating that a separate midwifery course poses "professional and educational difficulties" and reiterating the policy that midwifery was a postgraduate course of nursing. This recommendation was defeated.

<sup>12</sup> Figures released by the Hospital Boards Association (1984) showed that in 1982 there were 171 midwifery registrations, of which 147 were from overseas midwifery training programmes. Of those midwives who trained overseas, 39 were New Zealand registered nurses. In 1983-84 there were 169 overseas trained midwives registered in New Zealand, compared with 23 graduates from New Zealand midwifery courses. More recent figures are discussed later in this chapter.

some midwives and their consumer supporters, the key to getting midwifery re-established as a profession independent of nursing was the introduction of direct entry midwifery training. They believed that direct entry training would produce a midwife who was not only 'not a nurse' but also one who was capable of practising independently of medicine; the sort of practitioner who fitted the World Health Organisation (WHO) definition of a midwife. According to this definition, a midwife is a "person" who is qualified to practise midwifery. "She is trained to give the necessary supervision, care and advice to women during pregnancy, labour and the postnatal period, to conduct deliveries on her own responsibility, and to care for the newly born infant" (as cited in Donley, 1986: 13).<sup>13</sup>

#### **4.4 Consumer impetus for direct entry midwifery**

The consumer impetus behind getting DEM training re-established in Aotearoa/New Zealand came from members of the Homebirth Association in Auckland who formed a group called Save the Midwives in 1983.<sup>14</sup> They formed a 13-member taskforce in October 1986, under the leadership of Save the Midwives co-ordinator Judi Strid, which set itself the task of getting a DEM course ready to go within two years.<sup>15</sup> Differences of opinion amongst midwives over midwifery's position vis a vis nursing

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<sup>13</sup> This definition, which the midwives' section succeeded in having adopted at the NZNA conference in 1985 and was subsequently adopted by the NZCOM, continues: "This care includes preventive measures and the detection of abnormal conditions in mother and child, the procurement of medical assistance, the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for parents, but also within the family and the community. The work should include antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care".

<sup>14</sup> Efforts were being made at this time in various countries, including Britain and Sri Lanka, to get DEM courses either introduced or more firmly established. See Flint (1987), Kitzinger (1987), Radford and Thompson (1988) for discussion of the changing needs of pregnant/birthing women and the implications for midwifery. The movement in Aotearoa/New Zealand had contact with, and support from, these writers/activists as well as Marsden Wagner, the adviser on child and maternal health for the WHO.

<sup>15</sup> The taskforce consisted of five midwives and consumer representatives from home birth associations, La Leche League and Maternity Action Alliance. Marilyn Waring, a political economist and former member of parliament, was a 'consultant' member.

meant that the taskforce did not receive immediate support from the midwives' section for the introduction of DEM. Support was more forthcoming from those in the education sector, particularly in polytechnics, who saw it as an area where there was a demand for training that was not being met.

According to Strid, the "turning point" for those involved with the taskforce came when Guilliland took over leadership of the section in August 1987 (Interview: 1.2.94). Prior to this the section leaders had opposed the push for DEM on the grounds that it was unachievable, likely to confuse politicians and could undermine their efforts to establish separate midwifery diploma courses. Strid explained the taskforce's response to these concerns:

We felt that wasn't true, that politicians weren't that easily confused and that there were clear differences in the issues. Also that the strategies were being directed to quite different groups of women. That the one year course was for the registered nurses, while the direct entry course was for women who had no wish to become nurses ( Strid, Interview: 1.2.94)

Under Guilliland's leadership the midwives' section gave its official support to the taskforce and became involved in various strategies to raise the profile of midwifery and promote the DEM option. Strid recalled how people she met in the early 1980s knew very little about what midwives did:

It amuses me now when I think back to 10-12 years ago in Whangarei where we used to have stalls in the mall from time to time to talk about the role of midwives and also the option of home birth for women. It was just amazing - nobody knew what a midwife was. More people knew that they could have a home birth than knew what a midwife was. It didn't matter if you were talking to children, men and women our age or older people - there was no awareness of midwifery at all. Midwives just did not have a profile (Strid, Interview: 1.2.94).

A draft curriculum was developed and discussions held with various polytechnics that were interested in providing such training. In May 1988 a survey involving 4000 questionnaires was distributed to women's groups throughout the country to raise the profile of midwifery and gather information on the level of interest in DEM. Of the 690 respondents, 85 percent were unhappy about midwifery training, 80 percent thought midwifery was separate from nursing and 80 percent supported the establishment of a three year DEM course (Strid, personal communication).

A discussion document distributed by the taskforce to a range of consumer, education and cultural groups in 1990 identified midwifery as a profession which was concerned with the promotion of women's health. It was described as being centred on sexuality and reproduction and an understanding of women as healthy individuals progressing through the life cycle. It stated that midwives did not need nursing training as their focus was on "normality and wellness" (Direct Entry Midwifery Taskforce, 1990: 8). Citing the WHO definition of a midwife, it stated:

Although nursing education of today is centred on wellness, nursing arises out of either a disruption of wellness, or the prevention of that disruption. Neither applies to midwifery with its focus on normal pregnancy and childbirth, and the role of supporting the woman and her whanau during a normal physiological event.

In a section on 'community support and interest' the discussion document said there was a rapidly increasing number of community groups that were pledging their support for DEM in recognition of midwives' role as the advocate and specialist of normal birth. Through the distribution of such literature to a range of audiences the taskforce played an important part, not only in articulating differences between midwives and nurses, but also in (re)constituting midwives as "specialists" in normal birthing care. For those midwives seeking professional independence, the taskforce's activities

provided an important consumer mandate for their actions. This was evident in Guilliland's 1987-88 annual report to the midwives' section where she said:

This is undoubtedly a call for a re-evaluation of the midwifery service we provide and I personally believe it is our responsibility (given our philosophy of women-centred care) to respond to this call.<sup>16</sup>

Throughout 1988 Strid and the other taskforce members lobbied various members of parliament about the possibility of a private member's bill to change the legislation requiring midwives to first qualify as nurses. Their efforts to secure professional independence for midwives, as a forerunner to the establishment of DEM training, were greatly assisted when Helen Clark became Minister of Health in December 1988. As discussed in chapter three, Clark considered the loss of autonomy by midwifery to be an "injustice" and introduced the Nurses Amendment Bill in November 1989. While this bill did not address the issue of DEM education, Clark indicated her support for it when she addressed the NZCOM national conference in August 1990. She said:

As yet I have seen no evidence to persuade me that direct entry is neither feasible nor desirable. In the absence of such evidence it is my intention as Minister of Health to promote it in the context of the review of the Act. The objections appear to me to be doctrinally and not empirically based (Clark, 1990: 10).

Clark also expressed concern that the Nursing Council had turned down an application by Carrington Polytechnic for approval to run a pilot DEM course. She said she would be concerned if legislative barriers were removed and the council still showed no tolerance for an experimental programme followed by full registration. In fact, such a stance would "open up to question whether the Nursing Council is the appropriate body

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<sup>16</sup> Of her involvement with the taskforce, Guilliland said: "They are an extremely well organised, highly motivated group of women who understand perfectly the political nature of such an undertaking (canvassing New Zealand women and their families as to the support for a DEM programme). We are represented on this taskforce and I have found working with these women a powerful stimulant". See Guilliland (1988).



to govern midwifery" (Clark, 1990: 9-10). Within days of addressing the midwives' conference, Clark set in train legislative changes that would enable the introduction of DEM on an experimental basis. During the second reading of the bill, she introduced an amendment to Section 39 of the Nurses Act which allowed for the introduction of experimental DEM training programmes at two polytechnics.

As the legislation had already been to the select committee, there was no opportunity for further submissions to be made on the issue of DEM training. This meant that, for example, neither area health boards nor the Nursing Council had the opportunity to oppose these courses.<sup>17</sup> Any potential resistance to DEM from nursing leaders and employers was effectively bypassed as a consequence of the initiative taken by the Minister. Even DEM advocates, who had been lobbying for years to have it introduced, were taken by surprise at how suddenly it came about (Interview, Pairman: 25.11.93). The Minister's involvement in enabling DEM training to become a reality clearly angered members of the Nursing Council. According to Papps, who was the chairperson of the Nursing Council at the time, Clark exercised her political power to change legislation.

...whether this was because of the Nursing Council's philosophical perspective, which in terms of its legislated functions it had no mandate to make, or whether the 'direct entry' lobby had been effective, will probably never be known (Papps and Olssen, 1997: 170).

The outcome of the legislative change was that DEM training could proceed despite the "unreadiness of the nursing profession in general". As a result five polytechnics applied for approval to run pilot DEM courses. The Nursing Council approved the Auckland

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<sup>17</sup> A letter from the Otago Area Health Board to the Otago Polytechnic, sent in June 1991, stated that there would be no employment opportunities for direct entry midwives as the board would only employ midwives with nursing qualifications. It said that employing direct entry midwives would "introduce unnecessary rigidities" into the AHB workforce. The board was also concerned that there could be some difficulties with regard to the availability of "clinical material".

Institute of Technology (AIT), Carrington and Otago courses and all three gained approval and accreditation from the New Zealand Qualifications Authority (NZQA). In December 1991 the Minister of Health, Simon Upton, approved funding for pilot programmes beginning at AIT and Otago in 1992 (funding was for two intakes of 16 students each).<sup>18</sup> An evaluation process was set up to assess whether the courses produced the "desired outcomes" at a cost that was acceptable.<sup>19</sup> Intensive lobbying by the NZCOM, consumers and the polytechnics led to ministerial approval for two further intakes at both polytechnics in 1994 and 1995.

The introduction of DEM training was important not only in separating midwifery from nursing, but also in enabling midwifery to reconstitute itself as a 'women-centred' form of maternity practice. It was the public and political activities initially engaged in by maternity consumers/activists that significantly raised the profile of midwives as the most appropriate providers of normal maternity care. This consumer-led movement in Aotearoa/New Zealand, like its counterparts overseas (Flint, 1987; Kitzinger, 1988; Radford and Thompson, 1988), was highly vocal in its opposition to the medicalisation of childbirth and its support for the reinstatement of midwives as autonomous practitioners whose role was that of "advocate" and "specialist" of normal birth. This support from a group of highly organised and committed maternity consumers was both timely and influential given the interest state actors had in providing more cost effective, consumer-oriented primary health services.

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<sup>18</sup> Students wishing to enter direct entry midwifery programmes who held other qualifications such as nursing or physiotherapy had their relevant prior learning recognised. It was expected that a registered nurse would require from 12 months to gain registration and 18 months to gain degree qualifications.

<sup>19</sup> See programme evaluation by Ernst and Young (1993).

#### 4.5 Introducing DEM at Otago Polytechnic

In 1992 the Nursing and Midwifery department at Otago Polytechnic offered Aotearoa/New Zealand's first Bachelor of midwifery programme (the DEM course at AIT was for a diploma in midwifery). As one of the first educational settings to offer undergraduate midwifery training, it presented a strategic site for researching how midwifery was being reconstituted as 'specialist' maternity practice with its own knowledge base and framework of practical judgement. Of particular interest was the involvement of educators and practitioners in theoretical elaboration of midwifery's formerly tacit knowledge base. The programme had been underway for three and a half years when interviews were conducted with the then head of department, Alison Dixon, the midwifery course coordinator, Sally Pairman, and a number of students who were in their final year of training.

Prior to the introduction of this degree programme, Otago offered a one-year post-registration diploma of midwifery course.<sup>20</sup> Ironically, given the struggle to separate midwifery training from nursing training, the introduction of the DEM degree coincided with the introduction of a three-year Bachelor of Nursing degree with which it shared some components of the curricula.<sup>21</sup> According to the midwifery course co-ordinator, Sally Pairman, it was important that midwives had a qualification of equivalent status to that of nursing.<sup>22</sup>

It seemed to me that the midwifery profession should be aiming for a degree if that was where nursing was going. We are so closely linked in New Zealand at the

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<sup>20</sup> This course was one of several introduced around the country in the late 1980s to provide midwifery training separate to the Advanced Diploma of Nursing (ADN) midwifery option (which offered 10-12 weeks midwifery experience).

<sup>21</sup> The development of both these degree programmes was facilitated by the Education Act 1990 which allowed tertiary providers, other than universities, to offer degree qualifications.

<sup>22</sup> Pairman was also the president of the NZCOM at this time.

moment - and probably for some years - because all the midwifery training that happens is within a nursing department. I just felt that we would be disadvantaging ourselves to not have a degree when we had the opportunity to have one. I also felt that degree education was more appropriate for midwives who were going to be independent practitioners. If we were going to play the game of stacking ourselves up against another profession then we should have the equivalent qualification (Pairman, Interview: 25.11.93).

This comment highlights Abbott's argument (1988:316) about how the context in which a jurisdictional dispute takes place affects the outcome of boundary struggles between professional groups. He claimed that the context shaped "how much" abstraction was necessary for a profession to contest or defend a jurisdiction. In a context where nursing was endeavouring to enhance its status as a "skilled and indeterminate, theoretically informed activity" through degree-level training, midwifery was obliged to do the same so as not to lose professional ground. It was also a context in which midwives were competing against other highly qualified health professionals, particularly doctors, for clients and could be disadvantaged if their qualifications were seen as being of lesser status.

The challenge facing midwifery educators and leaders was to design a degree curriculum (a formal, codified knowledge base) for practitioners who had the legal right to practise as independent primary health care practitioners.<sup>23</sup> Their task was to construct a theory/knowledge base which underpinned midwifery as a form of autonomous maternity practice as opposed to specialist nursing practice. In reconstituting midwifery as autonomous practice, it was important that student midwives were given the knowledge and skills which would enable them to provide a particular form of expert maternity care. This form of maternity care was different in

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<sup>23</sup> The national framework for midwifery education, which was drawn up at the Vision 2000 forum in Auckland in 1991, recognised that the NZCOM had a legitimate role in shaping midwifery education and practice in New Zealand. All midwifery curricula were to be presented to the college's education committee for endorsement.

important ways from that provided by nurses and doctors. Given midwifery's involvement with nursing, both historically and in the contemporary training setting, the immediate task became one of sorting out their commonalities and differences.

In the preamble to the curriculum, Pairman stated that the midwifery profession shared common knowledge and skills with nursing, as well as other health professionals, but that each profession had its own unique body of knowledge and scope of practice which determined its separate status (Bachelor of Midwifery Application for Course Approval, 1991: xix). In the case of midwifery, this "unique body of knowledge" had existed largely in a tacit or oral form. With the granting of professional jurisdiction over normal maternity care came the need to formalise it into an explicit, research-based programme which would produce midwives with the knowledge and skills to practise as independent practitioners. Pairman described the need to shift from an oral tradition to a research-based training programme:

... we have this amazing oral tradition which we haven't been sharing and writing down. And I think in New Zealand we have lost such a lot of our knowledge because of the years of being obstetric nurses. To get that self esteem back for midwives - but also to know what it is that we do and to value that - we have to be able to write it down. So it was important that we had an education system that enabled midwives to learn how to do that (Pairman, Interview: 25.11.93).

This determination to formalise midwifery knowledge within a degree programme was encouraged by the department head, Alison Dixon, who had been steering her department toward providing degree-level nursing training for some years (Interview: 13.7.95). A chief concern of Dixon's was that the knowledge-base of any degree developed within the department recognised knowledge as subjective, context-bound, normative and, in an important sense, always political (Carr and Kemmis, 1986). In developing the new nursing and midwifery curricula, the department considered issues associated with the nature of knowledge, how it is generated and in what ways it is

transmitted.<sup>24</sup> In promoting concepts such as rationality, mutuality, trust and 'caring' as central to professional practice, it sought to legitimise knowledge derived from sources outside the dominant empirico-analytical paradigm.

The department's stance on the knowledge-base of nursing could be seen as an example of on-going efforts to reconstitute nursing as a theoretically-informed activity underpinned by a knowledge-base which was more inclusive than that of the instrumental scientific (cause and effect) model of medicine. This knowledge base recognised the value of, for example, the intuitive or tacit aspects of clinical judgement and the personal/experiential knowledge of the patient/client. Concern over these epistemological issues, and their implications for professional practice, was shared by key members of both the nursing and midwifery staff in the department. Hence the determination to construct a degree curriculum for each profession which legitimised, not only other ways of knowing, but also, as a consequence of regarding knowledge more inclusively, other ways of practising.

For midwifery educators this way of practising had to be organised around claims to expertise in 'normal' childbirth.<sup>25</sup> Their task was to provide midwifery students with a particular package of knowledge and skills which would enable them to practise as "experts" in normal childbirth. This expertise, according to the curriculum, involved "recognising when a woman or baby needs to be referred for specialist medical opinion". It stated that the midwife may continue to provide supportive midwifery care in these situations, but is not qualified to treat deviations from the normal (Bachelor of Midwifery Application for Course Approval, 1991: 2). This explanation of midwives'

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<sup>24</sup> The department drew on the work of Habermas (1971) to examine various categories of knowledge. The nursing and midwifery curricula states that technical, practical and emancipatory 'interests' each have an inherent place in the development of professional knowledge for nursing (and midwifery) practice.

<sup>25</sup> See discussion in chapter six of contestation over the meaning of 'normal' and 'abnormal' childbirth. According to a midwifery model, childbirth is normal 'in anticipation' while in a medical model it is normal 'in retrospect'.

expertise highlights the importance for professional practice of constructing and defending an area of work over which practitioners exercise 'expert' judgement (Brain, 1991).

For midwifery, the focus was on 'normal' pregnancy/childbirth, which it argued could only be defined on a case-by-case basis. From a training point of view, it was important to produce midwives who had not only the knowledge and skills but also the confidence to exercise judgements about what constituted 'normal' for each individual client. This concern with producing midwives who had both an understanding of childbirth as 'normal' and confidence in their ability to practise autonomously was described by Pairman:

There has to be professional judgement. But it is getting midwives to feel confident about their abilities to make those judgements. That is where I think the direct entry course has an advantage in that we have three years...The students don't have a nursing background that has taught them pathology and they don't have an underlying fear of birth...They are going to be really grounded in 'normal' and that is what midwives should be. If you understand the normal then you can recognise when its not (normal) for that particular woman. It is actually learning those grey areas for each woman - that's the skill - and being able to assess what is happening (Pairman, Interview: 25.11.93).

This description of midwifery expertise, as being exercised on a case-by-case basis, put the relationship between a midwife and client at the centre of midwives' professional practice.<sup>26</sup> In emphasising this relationship, it supports a form of midwifery practice organised around a "partnership between a woman and a midwife in their shared experience of childbirth".<sup>27</sup> Central to this partnership is the concept of continuity of

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<sup>26</sup> It also implicitly makes the relationship between the midwife and obstetric specialists (the experts in 'normal' and 'abnormal' maternity care) central to midwives' professional practice.

<sup>27</sup> The 'partnership' model of practice for midwifery was developed in monograph form by Guilliland and Pairman (1995) as a component of their Masters in Midwifery degrees at

midwifery care. This form of practice, in which a midwife or a small group of midwives provide care for the woman throughout her childbearing experience, was described as facilitating the development of trust which in turn "provides the foundation for a positive experience for each partner" (Bachelor of Midwifery Application for Course Approval, 1991: 2).

The development of a 'midwifery knowledge' paper within the degree programme was seen as crucial to producing midwives who practised in partnership with clients, rather than the medical profession. This paper looked at issues associated with the history of midwifery, and the philosophy, standards and framework of practice adopted by the NZCOM. Pairman described it as a particularly important paper as it was where the students were "grounded in the midwifery model". This model draws heavily on feminist theorising about women's right to control their pregnancy/birth experience in framing autonomous midwifery practice. Course co-ordinators found it a challenge developing this paper as there was relatively little written about autonomous midwifery practice, particularly with a feminist focus, either internationally or in Aotearoa/New Zealand.

When the DEM degree programme began it consisted of a combination of newly developed midwifery papers and papers that were shared with the nursing degree (most of the first-year papers were shared).<sup>28</sup> The decision to offer these shared papers was made on both professional/educational and financial grounds. According to Dixon, it was "not too difficult" to decide which were the discipline specific components of the degrees (Interview: 13.7.95). Initially, the professional knowledge papers were separate while introductory research and clinical skills, behavioural and physical

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Victoria University (offered since 1995). Their ideas on how partnership should be put into practice were presented at the NZCOM conference in Rotorua in 1994.

<sup>28</sup> These papers included an introduction to selected practice skills, bioscience, behavioural science, the family in the community, women in society, introduction to healthy behaviour, people of this place and an introduction to research skills.



sciences and communication were seen as being common to both degrees.<sup>29</sup> Given that the department could not afford to run the midwifery degree as a separate programme, this sharing of resources made economic sense.

Some of the students in the first DEM intake did not, however, share the view that midwifery and nursing training had much in common. They were resistant to being taught by nurses and challenged various aspects of the first-year programme. An example of an issue that caused some student concern was the requirement to wear a nurse's uniform and go into the public hospital for seven half-days for training in clinical skills. One student, for whom this was not a major issue, said there was protest within the class at having to learn what they perceived as being "nursing skills" (Interview: 6.7.95). Pressure from these students for more specifically midwifery clinical experience led to changes being made to the structure of the first-year programme.

Pairman described the first intake of midwifery students as being very different from the nursing students and having a big influence on the department, despite being fewer in number.<sup>30</sup> She acknowledged that complaints from some of these students contributed to a growing realisation that there was "much more that is different" between nursing and midwifery training than was first thought.

... the 20 midwifery students were incredibly visible within the department. They were women who had been hanging out to do direct entry for years - some had been involved in the consumer support for the change in the legislation. So they were

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<sup>29</sup> The midwifery and nursing students shared a year one bioscience paper in which they studied general systems. In year two they had separate papers with midwifery students focussing on the reproductive system for the first half of the year and patho-physiology (for example, the effects of hypertension, heart disease, infections etc. on the pregnant woman) for the second half.

<sup>30</sup> Eighteen of the twenty women in this intake were from various places in Aotearoa/New Zealand, the remaining two were full fee-paying overseas students (from Canada and the Solomon Islands). Two students did the course part-time. Almost half the students, whose ages ranged from 22 to 40, had children.

politically aware, articulate, mature women with a lot of life experience who were quite different from the school-leavers who made up the majority of the nursing students. They just blew the department away really (Pairman, Interview: 25.11.93).

A change to the first-year programme meant that subsequent students were given more opportunity for clinical midwifery experience. Instead of doing a clinical paper with nursing students, in which they visited families in the community with young children, the midwifery students were given more time to share the experience of pregnancy and birth with a woman. Acting as support people for the women and their families, the midwifery students ideally followed through one or two cases from early pregnancy to six weeks postnatally. The aim was to give them an understanding of the experience of pregnancy and birthing from the woman's point of view. Pairman explained the role:

They (midwifery students) go to her antenatal appointments with her and to whatever antenatal classes she's going to. They do a lot of work around how she is feeling and what choices she makes and what the experience is like for her. They go to the labour and birth - but they are there as a support person for her and her partner - and they play whatever role she wants them to play. And the same postnatally (Interview: 11.7.95).

Demands from students for more midwifery experience in year one also led to the introduction of more midwifery-specific skills. By 1995 DEM students were being taught various midwifery skills in addition to the basic nursing skills - such as taking blood pressure and temperature, testing urine, and making beds - that they learnt alongside the nursing students. These midwifery skills included palpating a pregnant woman's abdomen, carrying out a complete physical assessment, and doing venipuncture. Another change to the first-year programme meant that the midwifery students did not spend as much time in the public hospital as their predecessors and did not have to look after male patients. The opposition from midwifery students to nursing men caused considerable conflict in the department as Pairman explained:

People (in the department) were really upset that the midwifery students were saying that they would not nurse men. That took a lot of working through. For some of the students it was because they had had personal experiences that meant that they did not want to have physical contact with men. Mostly they said look we've come to be midwives, we are happy to be working with women but actually we don't want to be sponging 45 year-old males... in that intimate way you have to do when you are nursing. They argued that that was not what they were here for (Pairman, Interview: 11.7.95).

While the first year of the midwifery degree programme underwent some changes, the second and third years have remained relatively consistent with the degree programme introduced in 1992. With an increasing focus on midwifery practice, rather than nursing practice or midwifery theory, the course focus shifted from the philosophical to the practical.<sup>31</sup> Students spent their final year working in various types of maternity practice. Their practical experience included a four-week rural placement and 14 weeks spent with an independent midwife who provided mostly midwife-only care and did both home and hospital births. As well as learning hands-on midwifery skills, the latter placement provided students with some insight into how to run an independent practice.

Course organisers had some difficulties not only in providing access for students to the 'right' type of midwifery practitioners, of which there were a limited number, but also in ensuring that they were given the opportunity to develop their own skills. In some cases, the experienced midwife may no longer perform some of the routine skills that the beginning practitioner needed to master (like vaginal examinations). In other cases, the midwife may be keen to build up her own experience in performing certain skills, such as suturing and putting in intravenous drips, which were the prerogative of doctors before midwives gained autonomy. Pairman encouraged third-year students to take advantage of working alongside doctors as well as midwives to get the experience they needed.

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<sup>31</sup> The Nursing Council requires that clinical experience constitutes no less than 50 percent (1500 hours) and up to 60 percent of a three year midwifery course.

Anytime there is any suturing happening - if a doctor is doing it - they should put on their gloves and say 'Here I am, can I help you, can you supervise me doing this?' They have to try and get the experience that way. Any woman who is having an epidural or is having her labour augmented and needs an intravenous infusion that they say to the doctor, 'Can I put this IV in?' (Pairman, Interview: 11.7.95).

Third-year students were required to pass their papers and a series of competencies before being eligible to sit their state final examination, which was set by the Nursing Council.<sup>32</sup> Assessment of their competency in such areas as antenatal assessment, caring for a woman in labour, initial examination of a baby after the birth, daily examination of the woman and baby and breastfeeding was made by the midwives with whom they were placed. The department had run sessions at the polytechnic to assist independent midwives involved in assessing students' competency. While the department endeavoured to ensure consistency in terms of the skills the students were taught by practitioners and how they were assessed, it could not guarantee the outcome of this clinical experience.<sup>33</sup>

One strategy promoted by the department to help graduates build up their confidence during their first year in practice was for them to have an experienced midwife as a mentor.<sup>34</sup> This midwife would provide them with back-up and assistance if they got

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<sup>32</sup> Efforts have been made by the NZCOM and midwifery/nursing educators to drop the requirement for midwives and nurses to have to sit an external examination but it is required under the terms of the Nurses Act (1977). The midwifery state final consists of two one-and-a-half hour examination papers made up of multiple choice questions. See Robertson Green (1994) for discussion of the arguments advanced by nurse educators as to why an external examination is not an appropriate way to assess competency.

<sup>33</sup> Nor can it guarantee how consistent or useful the students' clinical experience is in base hospital maternity units. Pairman said that students placed in the delivery suite at Queen Mary hospital in Dunedin did not necessarily get the required experience if the unit was quiet and most births were being handled by independent contractors. This argument was used against the CHEs when they subsequently demanded that graduates had particular skills.

<sup>34</sup> The mentoring of new graduates was also promoted by the NZCOM. However, the college opposed efforts made by some CHEs to make having a mentor a condition for granting access agreements to newly registered practitioners. The CHEs also wanted to make mentor midwives legally responsible for the mentorees performance.

into a situation that they did not feel they could manage. However, this pairing of graduates and experienced midwives potentially created further difficulties for educators trying to access suitable clinical placements for students. With a limited number of practitioners working not only in an independent capacity, but also providing continuity of care according to the partnership model, it was often difficult to access suitable midwives to supervise third-year students in their clinical placements. If these midwives were also being asked to mentor graduates, this task became even more difficult.

This discussion of the introduction of a degree in midwifery at Otago Polytechnic has highlighted some key issues arising from interviews with course organisers. While it has endeavoured to present an accurate account of the beginning of DEM training, it has to be acknowledged that the information related to one course at a specific point in time. Subsequent changes in the Otago degree course were beyond the scope of this discussion. It is worth noting, however, that this degree programme did prove to be of particular interest in that some components of the curriculum were franchised to Christchurch Polytechnic for the Bachelor of Midwifery degree that was introduced in 1997. The next section of this chapter draws on interviews with two DEM students to see how this form of training prepares them to practise independently.

#### **4.6 Doing DEM training**

Carol and Donna (not their real names) were students in the second intake into the Bachelor of Midwifery degree at Otago Polytechnic and were mid-way through their final year when interviewed in July 1995. Both these women had graduated with science-related degrees before beginning midwifery training.<sup>35</sup> They were among a

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<sup>35</sup> Preference for selection for the Otago DEM course is given to applicants over 20 years of age who have science subjects to the sixth form level. Applicants who have left school without academic qualifications are directed towards a pre-health science course at a polytechnic to bring their science knowledge up to this level. The students are selected by a

group of six in a class of sixteen who were young and did not have children. Carol and Donna's accounts of direct entry training are not presented as being typical of DEM students' experiences or views. With a diverse range of students doing this form of midwifery training, there is no such thing as a typical student.<sup>36</sup>

The value of presenting a lengthy transcript of Carol and Donna's "talk" about their experiences as DEM students is two-fold. Firstly, it places on record two first-person accounts of aspects of this new form of midwifery training. Given the significance of this training to midwifery's ability to produce practitioners with the knowledge and skills to practise as experts in 'normal' pregnancy, it is important to hear accounts from some of the first students to undertake that training. These accounts include details about their individual backgrounds and motivations for doing midwifery as well as their training experiences and expectations for future practice.

Secondly, it shows how students appropriate key elements of midwifery's contemporary professional discourse in explaining their understanding of what it means to be a midwife. This discourse legitimates a particular form of midwifery practice which is organised around childbirth as a 'normal' physiological process, continuity of care and partnership with clients. While these elements are not always stated explicitly by the students, they make frequent reference to their "philosophical base" and their "framework for practice". They convey a strong sense of having a shared conceptual framework which underpins the model of midwifery practice in which they are being "grounded".

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panel of people including a consumer from the Home Birth Association, an independent midwife, the deputy head of the nursing and midwifery department, a lecturer in Maori and the course co-ordinator.

<sup>36</sup> While this discussion focusses on the comments of two particular students, it is informed by conversations with a number of DEM students from several intakes at the Otago Polytechnic who were at various stages of their training. It is also informed by presentations given by direct entry students from courses throughout the country to those attending the NZCOM national conferences in 1994, 1996 and 1998. These individual and group presentations, which often used music and dance to convey their messages, tended to be a highlight of the conference programme.

Carol and Donna's responses provide a useful insight into how DEM produces practitioners who share an understanding of childbirth as a normal, physiological process and of themselves as professionals whose focus is on providing independent midwifery care. These understandings are derived, as the students explain, from both the theoretical teaching they receive in the classroom and the various forms of clinical practice they experience in the workplace. Unlike some of their peers, neither Carol nor Donna had prior knowledge of the politics and philosophy of midwifery when they began the training.

Carol: For me the first year was a huge learning curve because I came to midwifery having done a degree in physiology and thought what am I going to do next. I applied for the course and got in. It wasn't something that I've always wanted to do. I come from quite a medical background - my mother is a nurse and my father was a gynaecologist. I was quite medicalised I guess in my mind and it was good to learn about midwifery ... although I don't think we need to undermine nurses. I think they are another group of women that get undermined. For me it was a huge learning curve and that's okay.

Donna: I'd have to agree with that as well. I always knew I wanted to do something with either obstetrics or midwifery and I knew I didn't want to do nursing first. So that had put up a barrier for me really until the course came along. It was a real eye-opener the first year the extent of the politics ...

Researcher: So neither of you went into the course with a knowledge of the political struggles which perhaps some of the others had. What was that like?

Donna: Sometimes I think our naivety wasn't appreciated.

Carol: No, but I argued with them. I stood up for myself. But I'm willing to take on things and I now think the political side of midwifery is very important - I'm really into it big time.

Donna: The people who were most frustrated (in the first year) were the ones that already knew the midwifery background. So they were coming in to learn how to practise. Whereas I found it all really interesting - all this stuff I never knew existed about midwifery.

These comments highlight differences among students both in terms of their expectations of the course and of midwifery itself. While some students had previously been involved in aspects of maternity politics and were knowledgeable about the midwifery/consumer struggle for autonomy and the introduction of DEM training, others were unaware of the background. For some of those students for whom the political struggle was familiar, the emphasis on feminist and midwifery theory/philosophy during the first two years of the course was frustrating. They were critical of this theory being taught at the expense of time spent learning clinical skills. Some students, who believed that they had not had enough clinical training, lacked confidence about embarking on independent practice.<sup>37</sup> These students articulated a tension between formal, theoretical education and knowledge learnt from experience in the clinical field.

Carol: I think we were quite lucky in second year too because we got good clinical experience. But I feel the philosophy and the socialisation we have had at polytech has been so important really because when you learn a skill - okay it is a bit nerve-racking when you first do it - but it is not that difficult once you've had the experience. I think that having your philosophical base to work from and your framework for practice is paramount. In some respects we may be losing out a little bit on the skills side of it but I don't think it is that unbalanced.

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<sup>37</sup> A third-year DEM student from the Otago Polytechnic told delegates at the 1994 NZCOM conference: "We get an abundance of the philosophy and politics of midwifery. We and our frameworks go everywhere together - we eat, sleep and breathe midwifery philosophy. What we are thirsty for is the practical experience". A first year student from the course said to me: "What gives you the confidence to go out and manage births is the practical experience. It's not knowing the difference between a lesbian feminist and a Marxist feminist as far as I'm concerned".



Donna: I'm not sure that we are losing out on the skills side of it - I think some people might have an attitude in their heads that because they haven't done nursing they haven't done a lot of these basic skills. But when I talk to midwives who did nursing and then did their midwifery - most of them only got between 15-20 births in their training. Well Carol and I have had a lot more than that and I guarantee most of the class would have at least that many.

Some students who expressed concern about a lack of clinical/practical experience in the midwifery degree programme claimed that it was due, either to a limited number of cases being available for "follow-through", or to their placement with an independent practitioner whose workload was light. Alternatively they may have been placed with an independent midwife whose clients, for whatever reasons, chose not to have a student involved in their care. For reasons like these, both the quantity and quality of clinical experience and skills training received by third year students was often highly variable. For their part, Carol and Donna were pleased with both the number and types of births that they had been given the opportunity to attend. Of particular value were opportunities to get "hands on" experience in 'normal' childbirth. These opportunities were not necessarily always facilitated only by midwives, as Carol's experience in Oamaru shows.

Carol: I started my third year two weeks after my second year exams. I went up to Wellington and did my elective there with the home birth midwives. I worked with them for 12 weeks and attended 16 births - seven of them were home births and the rest were in hospital. It was mainly midwifery only care. I didn't get a lot of hands-on but I got really good experience just sitting on my hands - which is what you have to do a lot of the time as a midwife. I found it really good up there and that's where I want to go back to practise. It's been really good for me to set up networks with the midwives and the women up there as well. And I have one woman who is waiting for me to go up so I can be her midwife.

I've also done my rural experience (in Oamaru) ... and the doctors (GPs) there were great about having me present. I actually conducted 11 deliveries by myself and they

were there as well. The midwives were really supportive once again and they had a really good philosophy.

Donna: I did what Carol did and went over the holidays - so two weeks after my exams I started my continuity placement in Auckland. I found I was quite prepared - I got a lot of hands-on in Auckland and saw all these normal births. I felt quite prepared for my elective - knowing I would come across the abnormal - because I had the basic skills of the normal there already in my head and a lot of the time in practise as well.

I did (my elective) in Dunedin with one independent midwife. It was supposed to be for 10 weeks but I think I've just done 15. I've been at 17 births with her and I've had a lot of hands-on - at just about every birth I think - hands-on for different aspects. We've worked with a lot of different obstetricians ... which was interesting to see how they practise differently. One of the reasons I picked this particular midwife was that she works with a group of obstetricians - she has a lot of abnormal births. I did my continuity experience with a midwife who does total midwifery care so everything was normal.

So I picked this midwife because I knew I would come across some different aspects of childbirth that weren't perhaps fitting into the normal and that did happen. She does do total midwifery care and we did have a couple of those cases. Most of hers are coming at the end of the year which she was really apologetic to me about but I found it interesting to see women with hypertension, previous placental problems and following them through. So I was quite glad of that experience.

The purpose of providing an extended excerpt from the students' accounts of clinical placements is to give an indication of the sites and forms of practice in which they have been situated. Knowing the contexts in which they have been learning clinical skills is important in understanding the form of maternity practice that they are being trained to provide. This is because the context itself constitutes an essential part of the work activity. It is in particular locations or situations that they, as trainees, learn how to make sense of puzzles or problematic situations in relation to childbirth. They also learn

how to pursue possible courses of action. What is important in these training situations is that the experienced practitioners share their tacit knowledge and embodied skills.

This point highlights the importance for the profession's educators/leaders of placing trainees with midwives who practise according to the particular model of midwifery that they promote ie. the 'partnership' model. These practitioners provide a vital link for the students between the theoretical/philosophical ideas they are introduced to at the polytechnic (the abstract knowledge base) and the application of those ideas in a particular form of midwifery practice (the framework of judgement). It is through working alongside these practitioners that students learn, not only how to perform certain required skills but also, very importantly, how to exercise 'expert' judgement in relation to what constitutes normal childbirth. It is the capacity to exercise this judgement that is the basis of autonomous midwifery practice.

While the NZCOM has resisted quantifying the number of births that students need to attend in training, because this does not necessarily indicate their competence, the students recognised the value of being involved in as many births as possible. However, it is not just the number of births that they attend that is important to their development as midwives who regard childbirth as a normal process. Of greater significance is that they are involved in the 'right' type of births ie. births in which continuity of midwifery care enables women to have confidence in their ability to give birth without the need for medical intervention. The students' sense of professional confidence, of themselves as autonomous birthing practitioners, relied heavily on the knowledge gained through clinical experiences.

Donna: I know that numbers (of births) aren't important but for me quantity does matter for my personal confidence. I can say to myself look you've seen a lot, you can do this, you've seen this before or done that before. It seems to help me a lot.

Carol: Because even if you're not actually doing it, you're seeing it and you're taking it on board and adding to your own confidence level as well.

Another aspect of the clinical training experience that can influence direct entry students' conception of themselves as autonomous birthing practitioners, and their entry into the labour market after registration, is their introduction into networks of relations with self-employed midwives. Opportunities for entry into established independent midwifery practices are often created as a consequence of clinical placements. It is the support offered by these experienced midwives, who effectively act as 'mentors' for new graduates, that encourages many direct entry students to bypass hospital employment in favour of self-employment.

Carol: I want to work independently and hopefully with the midwives that I worked with in Wellington. If not, I'll approach other midwives up there. I'm prepared to do shared care and hospital births because I think that at the moment there is not enough demand for just home births - until I get a bit more experience too.

Donna: I'm going back to Auckland - the midwife I was working with said she would possibly mentor me into independent practice with her - starting off on a small scale.

Contributing to these students' preference for independent practice is a concern that they could potentially lose their focus on childbirth as 'normal' if they were working in base maternity hospitals. They did not accept the suggestion that there could be some value in working in a hospital post registration to develop certain skills, such as suturing and the use of intravenous drips, that they may not have gained much experience and/or confidence in during the course. Both students were more concerned at the prospect of losing the knowledge and skills that they had acquired in (managing) childbirth as 'normal'.<sup>38</sup>

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<sup>38</sup> It should be noted that these interviews were conducted in mid 1995 - prior to the introduction of the Section 51 maternity funding arrangements and the development of

Carol: The course has been such that if you go into a hospital I think you'd find it very difficult. When you go to births in hospital - and you have an abnormal or whatever - it is so easy to lose your perspective on what is normal. That is what I have found and other students have mentioned it to me as well - how easy it is to slip back into saying 'patient' and just little subtle things like that that the system does push you towards... It would be a sad thing to lose the skills in the normal that we do have. And not to have the rapport with the woman because that is job satisfaction for me - having that relationship with the woman and her family and going through such an amazing event. You are so privileged to be involved in it. It seems such a shame to just walk in and walk out - for me that would be the shame if I had to work in hospital.

Donna: And realistically - what kinds of skills are you picking up working in a base hospital? If you are in a birthing suite, a lot of women have independent midwives so the numbers have gone down. Staff midwives are getting to do less and less. They are used in caesar theatre now and taking care of very sick women with diseases and disorders... If you are working with women having abnormal births and having intervention then you lose your focus on what is normal. You have to have the confidence that women can do it - and it is undermined in yourself if you experience a lot of abnormal care.

This talk confirms the centrality of an understanding about childbirth as an inherently normal process to midwifery as an autonomous form of maternity practice. It also highlights continuity of care as a preferred form of practice for direct entry trained midwives. These students explain their resistance to employment as staff/core midwives in a base hospital because it could involve them 'just walking in and walking out' and missing out on getting to know the women and their families in their own environments. For these prospective midwives, the concern is not simply to be involved in 'normal' births, but also to practise in such a way that they are involved in follow-through relationships with birthing women and their families.

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midwifery services in/from hospitals which provided continuity of care. The students comments relate more to the services provided by 'core' midwives doing rostered shifts in labour/delivery suites.

## 4.7 Midwifery and nursing

By the time I finished I felt that I could start as a midwife. I think we had a lot better start in terms of our clinical and our theoretical than the poor diploma people. I really start to pity them now because they come on night shift at Christchurch Women's... and may have only seen two births by half-way through their training. So the hands-on thing is very limited. Comparing our course with the diploma - it was just in a different ballpark (DEM graduate: 6.7.95).

With the introduction of DEM degree programmes at five polytechnics throughout the country, midwifery leaders and educators were keen to see an end to an alternative form of training for registered nurses who wanted to become midwives.<sup>39</sup> The NZCOM opposed retention of the one-year midwifery diploma programmes for registered nurses which had been offered prior to the introduction of the degree. It argued that nurses should be required to undertake a Bachelor of Midwifery degree programme with credits being given for prior learning and experience. Submissions to the Ministries of Education and Health claimed that nurses had a right to a degree programme which provided parallel clinical experience to that being given to direct entry midwifery students (Pairman, 1997; Guilliland, 1998).

Of particular concern to the college was the fact that the diploma training option perpetuated the concept of midwifery as a post-registration option for nurses rather than a distinct career change.<sup>40</sup> Not only did the diploma course hinder its efforts to

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<sup>39</sup> Direct entry midwifery degree programmes began at Waikato and Wellington polytechnics in 1996 and Christchurch Polytechnic in 1997. The Waikato polytechnic offers a parallel programme for Maori midwifery students (the first intake consisted of 10 Maori students and 10 Tauwiwi or Pakeha students). According to the programme coordinator, Becky Fox, the philosophy behind the parallel programme was "not one of a separatist nature... but a real attempt to have other areas of knowledge recognised as having equity with the mainstream paradigm". This statement was made during a workshop presentation at the NZCOM conference in Auckland in 1998.

<sup>40</sup> Postgraduate qualifications in midwifery are now being offered at several universities. These include a Masters qualification at Victoria University and a Masters and PhD programme at Massey University (at both the Palmerston North and Albany campuses).

consolidate midwifery as separate to nursing, but it also produced midwives that lacked the confidence to practise autonomously. According to one midwifery educator (Pairman, 1997: 9-10), the one-year programme disadvantaged nurses because it was not long enough for them to acquire the skills and knowledge necessary to practise as an independent midwife. She claimed that unnecessary stress was being put on both the staff and students involved in these courses in their efforts to meet the standards required for midwifery registration.

Whilst the Ministry (of Education) continues to insist that polytechnics run the one-year programme, and funds this at a higher level than the direct entry programme, registered nurses will continue to find midwifery education frustrating and stressful (Pairman, 1997: 10).

Despite any frustrations nurses may have with the one-year midwifery diploma, they have not opted in significant numbers for the degree programmes.<sup>41</sup> This may be due to the perception that the direct entry courses do not cater for midwifery students who do not plan to fit the model of autonomous practitioner advocated by the NZCOM. For some nurse/midwives who belong to the NZNO, there is a concern that the degree programmes offer a limited focus on shared care and insufficient experience of both normal and abnormal midwifery practice (Kai Tiaki, 1998a). They have requested that the NZNO develop policy statements on the issue of a new graduate's ability to practise competently as an independent midwife and offer postgraduate education specific to midwifery practice.

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The first PhD in Midwifery was awarded to a midwifery lecturer, Val Fleming, at Massey University in 1995. Plans for a postgraduate midwifery programme based at Otago Polytechnic, but available to midwives throughout the South Island, are currently on the drawing board.

<sup>41</sup> Only a small proportion of the students undertaking the various Bachelor of Midwifery degree programmes are registered nurses. For example, of the 60-80 applicants each year for the degree programme at Christchurch Polytechnic, there is on average about five registered nurses. With credits for prior learning and experience, it takes most nurses about two years to obtain midwifery registration.

Needless to say these requests, coupled with a call for greater representation of midwives by the NZNO, have not been welcomed by the NZCOM (*Kai Tiaki*, 1998b). According to the college director, Karen Guilliland, the midwifery workforce is too small to accommodate representation by two separate, and inevitably competing, professional organisations. She rejects any suggestion that the college is unable to represent the views of all midwives, including those who belong to the NZNO (over half of whom are also members of the NZCOM). However, one issue that is definitely a source of conflict between the NZCOM and the NZNO midwives is the NZNO's support for the retention of a joint Nurses and Midwives Act (*Kai Tiaki*, 1998a). The college is pushing for a separate Midwives Act and the introduction of competency-based practising certificates for the two registrations.

The introduction of competence-based annual practising certificates for both nurses and midwives has been on the Nursing Council's agenda since 1994 (Nursing Council of New Zealand, 1996). The council has been working towards implementing a system, similar to that governed by the Medical Practitioners Act 1995, whereby conditions are placed on the issue of annual practising certificates. These conditions could mean that registered nurses and midwives have to provide evidence of their continuing competence to practise in particular areas. Practitioners who have been out of practice for five or more years may be required to demonstrate their current competence during a period of instruction/supervision. However, before such a system can be implemented, changes are required to the legislation governing the practice of nurses and midwives.

Debate over guidelines for these certificates again highlights differences and tensions that exist within midwifery with respect to forms of practice. According to draft guidelines produced by the Nursing Council, there may be a requirement for midwives to demonstrate competencies "throughout the maternity experience" to maintain their annual practising certificate, ie. competency in providing continuity of care. This



requirement would be of concern to midwives who provide aspects of midwifery practice such as 'core' duties in hospitals, labour-only or post-natal care (Manchester, 1999: 12). Like nurses who specialise in areas of care, these midwives regard themselves as highly skilled in the provision of particular maternity services (see chapter six). However, they fear they could be denied a competence-based practising certificate for registered midwives because they do not provide continuity of care.

Whatever the outcome of this debate, it points to the complex relations both within midwifery, and between midwifery and nursing, nearly a decade after the Nurses Amendment Act. While midwifery leaders are endeavouring to secure legal separation of the two professions, so that midwifery rather than nursing has statutory authority over midwifery training and practice, some groups within the profession continue to identify more strongly with nursing. Midwives who belong to the NZNO (or have dual membership) believe that their professional concerns are more likely to be represented by this organisation than the NZCOM, which they perceive as being primarily concerned with the interests of independent or self-employed midwives. As midwives who either do not choose, or do not have the opportunity, to provide continuity of care, they are uncomfortable with the model of practice promoted by the college.

The college's strategy for enhancing midwifery autonomy, ie. constituting midwives as specialists in 'normal' or primary maternity services who provide continuity of care in 'partnership' with clients, has delegitimated other forms of practice as not being 'authentic' or 'true' midwifery. This strategy enables the college and practitioners to make particular claims over maternity work which undermine the social relational monopoly of control that general practitioners have had over childbirth. However, it also constrains the ways in which midwives can move to reconstruct the maternity field so as to give themselves a more central role. In shifting away from a model of practice that involves specialist obstetric nursing knowledge and skills, midwifery

leaders/educators have not only alienated some practitioners but also forfeited the profession's claim to this area of expertise.

An advantage of staking a jurisdictional claim over primary, rather than secondary, maternity services has been the opportunity to present midwifery as a more cost effective and consumer/woman oriented service than medicalised maternity care. The effectiveness of these claims in a context of health sector restructuring was discussed in chapter three. Analysis of the introduction of the Nurses Amendment Act highlighted the role played by state actors in granting legal jurisdiction over the provision of particular 'expert' services. This theme is addressed again in the next chapter which examines contestation between midwives and doctors over major changes in government policy relating to the funding and provision of primary maternity services, and the implications of these changes for patterns of professional control.

## **Chapter Five**

### **Competing for control: midwives, doctors and the state**

#### **5.1 Introduction**

As a consequence of the Nurses Amendment Act 1990, a significant number of practising midwives moved out of hospital employment and set themselves up in independent practice. As autonomous/private practitioners, offering publicly-funded maternity services to women with 'normal' or low-risk pregnancies, these midwives were in competition with doctors (particularly general practitioners) for a share of the maternity market. While some independent midwives chose to provide care in collaboration with general practitioners, most moved relatively quickly into providing domiciliary and/or domino services in their own right (see chapter six). With a limited number of potential clients for primary maternity services, the competition that developed between these two professional groups for clientele was intense.

A key site in which this interprofessional rivalry was played out was the negotiations that took place between state actors/managers and representatives of the professional associations over the funding of maternity services. These negotiations, which frequently became highly publicised disputes, initially centred on the maternity benefit schedule (MBS) which enabled both doctors and midwives to provide primary maternity care on a fee-for-service basis. However, following a "blowout" in the maternity budget, the focus of negotiations shifted to the introduction of a fee-per-case, modular payment system. Under this payment system, a provider/practitioner selected

by the client effectively held the budget for her care and was responsible for subcontracting any services that he/she did not provide.

In providing a detailed account of this contestation between doctors, midwives and state actors/managers over funding arrangements, this chapter highlights the significance of these arrangements for the status of the professions. It shows how the apparently arcane details of payment regimes have major consequences for medical and midwifery 'autonomy', forms of practice, and relations with clients and other practitioners. It argues that the outcome of negotiations over funding regimes has significant implications for each profession's jurisdiction vis a vis the other in terms of sustaining or undermining that position. Arrangements can advantage one profession more than the other in terms of its capacity to defend its jurisdiction and/or encroach on the jurisdiction of the other. The fact that the professional stakes are so high accounts for the intensity of the struggle.

The chapter begins with discussion of the health 'reforms' introduced by the National government in 1991 and implemented, to varying degrees, from 1993 onwards. This restructuring of the health system around contractual relations between the purchasers and providers of health care provided the context/rationale for the introduction of more competitive contracting into the primary maternity sector. In introducing these changes to the funding and provision of maternity services, despite intense opposition particularly from the medical profession, state actors significantly shaped the opportunities available to doctors and midwives for autonomous practice. This provides further evidence for the argument, presented in chapter three, that the state plays a crucial role in constituting, reproducing or diminishing the jurisdiction that professions have over the provision of particular 'expert' services.

## 5.2 'Big bang' health care reform

In July 1991 the National Government outlined plans for the radical restructuring of the health sector (Upton, 1991). These plans were contrary to National's 1990 election manifesto, but in keeping with arguments advanced by Treasury and various independent reviews throughout the 1980s, eg. the Gibbs Report (Gibbs et al., 1988) and repeated in Treasury's briefing to the in-coming government (The Treasury, 1990).<sup>1</sup> The thrust of these arguments, as outlined in chapter three, was the need to shift from an integrated (or administered) model of health funding and provision to a contract model. Central to the contract model was the separation of responsibilities for purchasing and providing health services and the introduction of competition among and between funders and providers. This competition, it was argued, would lead to rapid increases in productivity.<sup>2</sup>

The National Government's adoption of this strategy for rationalising the health sector was, however, consistent with other measures it was pursuing to reduce the fiscal burden of the welfare state.<sup>3</sup> Under the leadership of Jim Bolger, the National Government had put greater emphasis on a targetted approach to welfare in which state

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<sup>1</sup> National's Manifesto (1990: 4) stated: "The primary funding of hospitals will continue to be provided through area health boards made up of both freely-elected and appointed members. These boards were introduced by National and we will retain and support them".

<sup>2</sup> This briefing document stated that effective cost control was likely to involve more than just competition among providers. It stated (1990: 124) "prospective payment systems (which fix in advance the price paid for treating patients) and/or management systems which discourage unnecessary tests and treatments can help to minimise the cost-control problem that arises when doctors and patients do not face the costs of their decisions". The government's intention therefore was to shift to competition within capped budgets/fixed fee funding arrangement - as accomplished in the primary maternity sector with the introduction of the Section 51 Maternity Notice.

<sup>3</sup> The fact that western nations would face a 'crisis of welfare' in the run-up to the next century was forecast by the Organisation for Economic Cooperation and Development (OECD) in 1981. This 'crisis' would be caused by rapidly growing numbers of elderly people in proportion to the number of wage earners in the population, low economic growth and taxpayer resentment at the 'burdens' of welfare. A yawning gap was forecast between anticipated social expenditures and resources. Particularly alarming were the estimated costs of pension commitments already undertaken, and the projected costs of stubbornly high rates of unemployment (OECD, 1981).

support and subsidy was concentrated on those who were unable to provide for themselves (Bolger, Richardson and Birch, 1990). National introduced public sector reforms which separated the funding, providing and regulatory roles of government agencies. Separation of funding and provision meant that public sector agencies had to compete with alternative providers of service from the private and voluntary sectors.

Changes made in 1990 to social security and social service provisions had altered the availability of assistance so that people were more reliant on themselves, their families and the market economy and less reliant on the state (Scott, 1994). In the introduction to *Your Health and the Public Health*, the Minister of Health Simon Upton (1991: 1) stated that the country's poor economic performance and high levels of overseas debt meant that the Government could no longer afford to fund the open-ended commitment to health services laid down in the 1938 Social Security Act.<sup>4</sup> As in other areas of social policy, the Government needed to limit its liability and shift the costs of providing services back to individuals and families.<sup>5</sup>

In proposing significant institutional restructuring of the health sector, Upton (1991: 8) argued that area health boards (AHBs) suffered from a number of structural difficulties that prevented them from operating effectively. They were perceived as having conflicting roles as both the purchaser and provider of services. This dual role meant that boards had strong incentives to purchase their own services even when other more efficient and appropriate providers were available. They were also seen to be operating in a policy framework that placed too many constraints on the way they used their

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<sup>4</sup> This report was also known as the Green and White Paper. The two colours indicated a desire for the document to be regarded in part as a discussion (green) paper and in part as a (white) policy paper. Commentators (eg. Ashton, 1992; Easton, 1994) noted that the paper was more white than green given that there was little or no room for any discussions or submissions from interested parties prior to the introduction of legislation to implement the reforms.

<sup>5</sup> A taskforce, consisting of representatives from the health and business sectors, was appointed by Upton in 1990 to advise the Government on a solution to health sector problems. The taskforce's terms of reference reflected the government's emphasis on individual responsibility for health.

resources and offered only weak incentives for them to use their resources efficiently. As a consequence, boards tended to reduce costs by cutting services (Upton, 1991: 23-26).

Upton (1991: 9) also noted that when AHBs wanted to reduce services or make changes to the delivery of a particular service, they would often encounter public opposition that hampered their ability to make decisions. This "politicisation of the decision-making process" encouraged boards to shift the responsibility onto government through claiming a lack of funding instead of improving their own efficiency. It also meant that there was little opportunity for AHBs to open up a "diverse new range of health services". By weighting funding in favour of hospitals and secondary care, the boards were advantaging clinicians and providing "little incentive to move to community, day-stay or outpatient care, even where this would serve patients better and offer greater value for money" (Upton, 1991: 13).

Another concern that the Government wanted to address through the reforms was fragmentation of funding for health care. While funding for secondary care was distributed on an adjusted population basis to AHBs, primary care was funded through a "bizarre mixture" of subsidies (Upton, 1991: 14). These subsidies were set at widely varying levels, between zero and 100 percent, and there were no limits on the number of services for which the subsidy could be paid. Hence, the spending on primary care was open-ended.<sup>6</sup> The Government had no ability to control either the price or volume of services in this sector.<sup>7</sup> With expenditure increasing steadily (Ashton, 1992; Scott, 1994), the Government was keen to introduce incentives for efficiency and accountability into the primary sector.

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<sup>6</sup> The Government's strategy for getting rid of fee-for-service subsidies for primary maternity services is discussed further on in this chapter.

<sup>7</sup> In 1990/91 the Government paid out approximately \$945 million in primary care benefits for services such as laboratory tests, visits to the doctor and X-rays. Details on the primary health benefits system is contained in Scott et al. (1986).

A further concern in relation to government subsidies was that they were tied to particular providers and services in such a way that there were few incentives for innovative health care. Upton claimed (1991: 17) that this resulted in health services not being sufficiently responsive to consumers' changing needs. He cited submissions to various reviews of the health system which had described health structures as "male-oriented, monocultural and dominated by medical models". There were few services that were designed to meet the needs of particular groups, like Maori and women. According to Upton (1991: 17), there was "a strong desire among many consumers, and among some health providers, for greater diversity of services".

In promoting this notion of 'consumers' having more 'choice' about the health services they wanted, in a system organised around competition between providers, Upton and the National Government were following closely in the footsteps of their counterparts in the United Kingdom. Proposals advanced by the Thatcher government in 1989 for creating an 'internal market' in the National Health Service were passed into law in 1990 despite strong opposition from the medical and nursing professions (Ham et al., 1990; Ham, 1997; Ranade, 1994; Klein, 1995; Klein et al., 1996; Saltman and Von Otter, 1992; Harrison and Pollitt, 1994).<sup>8</sup> This model of health care, like the Aotearoa/New Zealand model, was shaped by New Right concerns with the efficient delivery and financing of services and issues of consumer choice.<sup>9</sup>

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<sup>8</sup> The white paper setting out the proposals for the UK health reforms was called *Working for Patients* (1989). The proposals passed into law in the 1990 NHS and Community Care Act and implementation of the reforms began in 1991.

<sup>9</sup> Discussion of the implications of a quasi/internal market in health care for the funding and provision of hospital-based midwifery services is the focus of chapters seven and eight.



### 5.3 New health structures

As noted earlier, the central focus of health sector restructuring was the splitting of the purchaser and provider roles previously carried out by the AHBs.<sup>10</sup> The fourteen boards were replaced by four regional health authorities (RHAs) whose role was to assess the health service requirements of their populations and to purchase services as necessary from the most cost-effective providers.<sup>11</sup> These independent Crown agencies were required to purchase primary and secondary health services from funding allocated on the basis of the size and characteristics of the populations they served.<sup>12</sup> Working within capped budgets, they were required to contract with service providers from the public, private and voluntary sectors that offered the best value for money.

According to Upton (1991: 41), the RHAs would strive to buy "integrated, managed care" for every member of their population.<sup>13</sup> This would be achieved through better co-ordination in the management of total health care across general practice, other community-based services and hospital services. It was up to the RHAs to pursue a diverse range of contractual arrangements with providers of both primary and secondary health care services which would allow "more innovation in service delivery,

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<sup>10</sup> The Green and White Paper proposed the establishment of a non-government purchaser called a 'health care plan' (HCP) which would offer clients an alternative to RHAs. People would be able to take their health care "budget" from an RHA and opt for coverage through a private HCP. Thus the intention was to introduce competition amongst purchasers as well as providers. However, HCPs did not eventuate largely because of opposition from health professionals and the public who feared it would lead to privatization of health care funding and provision (see Easton, 1994; Atkinson, 1994; Fougere, 1994b).

<sup>11</sup> The discussion in this section is in the past tense because the RHAs were replaced by a single purchasing authority called the Transitional Health Authority (THA) in 1997. This authority became the Health Funding Authority (HFA) in October 1998.

<sup>12</sup> This funding included money previously spent on the maternity benefit, AHB funding, pharmaceuticals benefit and the general medical services benefit (GMS).

<sup>13</sup> A National Core Services Committee was established to determine the 'core' health services that should be purchased. Core services were defined as those health care and disability support services to which everyone in New Zealand should have access at an affordable cost and within a reasonable waiting time (see discussion in Cumming, 1994). The concept of core services, along with the HCPs, was not implemented.

more choice of styles of health service delivery and better cost-containment (Upton, 1991: 59-60). The rationale was that competition amongst providers for contracts would encourage greater efficiency in the provision of services.

These providers included both health service facilities and health care practitioners. As a consequence of restructuring, public hospitals were constituted as autonomous, publically-owned business units called 'Crown Health Enterprises' or CHEs. The CHEs, which consisted of stand-alone hospitals or groups of hospitals and other service facilities, were to be run on a "business-like" basis by boards of directors appointed by the government.<sup>14</sup> Their funding would be directly related to their ability to compete with other public, private and voluntary providers for RHA contracts. These contracts, or service agreements, would specify the costs, quality and quantity of care that should be provided.

By making RHAs responsible for purchasing both primary and secondary services, the Government was hoping that they could make the difficult rationing decisions that AHBs were seen to be incapable of achieving (Ashton, 1992; Easton, 1994; Scott, 1994). The RHAs' capacity to make these decisions was to be aided by a new institutional structure which arguably insulated them from the professional and community interest groups that had 'captured' their predecessors.<sup>15</sup> According to Fougere (1995, 1997), providers were to be held at arm's length by the separation of purchasing and providing and the use of a formal contracting process. Communities, too, were to be held at arm's length by the shift from direct representation to

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<sup>14</sup> Modifications to the Health and Disabilities Services Bill in 1993 called for CHEs to exhibit a sense of social responsibility and to be "as successful and efficient as comparable businesses owned by the Crown". This modification followed widespread concern about the Government's proposals to make CHEs largely motivated by profitability. See Scott (1994).

<sup>15</sup> The Green and White Paper recognised the "deep-seated suspicion" that medical professionals have regarding any contractual relationship with the Government. By devolving responsibility for purchasing services, rather than "subsidising providers", to the RHAs the government was hoping to partially allay doctors' concerns about negotiating subsidies for primary care.

consultation. This would enable RHAs to act pre-eminently as agents of central government, ensuring that resources were allocated to what policy makers saw as their most effective uses.

Of priority in this new health purchasing environment was the need to reduce the level of spending on secondary medical services. In pursuing new contractual arrangements, the RHAs were expected to place increasing emphasis on primary and preventive care services which had the potential for reducing demand for more expensive secondary care services. However, the onus was also on them to find ways of containing the level of primary care spending. If the RHAs failed to do this, Upton said (1991: 48) there was a risk that demand would lead them to over-spend their budget or reduce the funding available for other services. Various methods could be used to achieve this aim including developing a range of contractual arrangements and payment systems for some primary care providers.

#### **5.4 Purchasing maternity services**

Among the primary health services to be purchased by the RHAs were normal or low-risk maternity services which had, since 1990, been provided by both doctors and midwives on a fee-for-service basis. As private or self-employed (independent) practitioners, doctors and midwives claimed fees from the Department of Health according to the Maternity Benefit Schedule (MBS). This schedule was established in 1939 as a means to pay general practitioners, on behalf of their clients, for the provision of maternity services. It was originally based on a global, one-off fee for all childbirth services. During the 1940s the Department of Health introduced specific fees for antenatal, perinatal and postnatal services. In 1966 a fee-for-service contract was introduced at the behest of the New Zealand Medical Association (NZMA).<sup>16</sup>

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<sup>16</sup> By 1989 the fee was set at \$285 for the doctor for appearance at (or after) a birth, at home or in a hospital. If the doctor was there for longer than one-and-a-half hours 'for

The Nurses Amendment Act 1990 enabled midwives to claim equivalent benefits under the schedule on behalf of their clients. They, like doctors, received a negotiated or set fee for each consultation or procedure. These payments were received irrespective of whether the practitioners provided the services independently or in a shared care arrangement. From the perspective of a funder/purchaser, the open-ended and demand-driven nature of this payment system made it difficult to either anticipate or control the expenditure on maternity services.<sup>17</sup> A Health Department review of the MBS (1992) recommended changes that would increase the level of control over claiming practices. These included restrictions being placed on both the number of claimants per labour/delivery and the maximum number of hours for which they could claim.

Upton told midwives at the NZCOM conference in 1992 that the fee-for-service arrangements led to over-servicing and provided little formal performance-related accountability between the Government and providers. He also claimed (1992:14) that they led to rivalry and poor communication between the main providers - general practitioners, obstetricians and independent midwives - and hampered integration of their services. He favoured the purchasing of maternity services that actively encouraged women to get the care that was most appropriate to their needs. Upton said that RHAs would want maternity services to be accessible, efficient and safe for women and babies (1992: 14). These services would have to give women scope to choose their own provider. The RHAs would also consider the extent to which a

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medical reasons or other special circumstances' a prolonged attendance fee of \$69.80 per half hour was paid. By contrast, domiciliary midwives received \$225 for care during labour and delivery (up to six hours) plus \$37.50 per hour thereafter.

<sup>17</sup> National MBS expenditure for the years 1986-1994 was: \$20.2 million (1986), \$30.4 million (1987), \$35.3 million (1988), \$40 million (1989), \$47.5 million (1990), \$58.9 million (1991), \$62.7 million (1992), \$78.2 million (1993) and \$89.6 million (1994) (Muthumala and Howard, 1995: 59, 68). MBS expenditure accounted for approximately one-quarter of the total maternity services budget in 1994 (with the balance of the budget being spent on maternity hospitals' salaries, supplies and facilities).

service integrated primary and secondary components and how successfully it enabled them to control their expenditure.

On assuming responsibility for the purchasing of health and disability services for their regions in July 1993, the RHAs set up a joint maternity services project. The first phase of this project was undertaken by the accounting firm of Coopers and Lybrand.<sup>18</sup> A report released in November 1993, entitled *First Steps Towards an Integrated Maternity Services Framework*, advised the RHAs on what services should be purchased in order to ensure quality birth outcomes.<sup>19</sup> This report supported the Government view that the MBS was geared towards funding providers to deliver services and paid little heed to the appropriateness or accessibility of those services. It argued that such a system had few, if any, safeguards against services being delivered when they were not needed and was also unable to ensure that every woman and/or her baby who required a particular service received it. It noted that there were women, or groups of women, whose needs were not adequately met by the current system.

Women who are isolated or from a low socio-economic background are often unable to access the services they need, while women from higher income groups may sometimes receive more services than are strictly necessary to ensure a health outcome for mother and baby (Coopers and Lybrand, 1993: 19).

The report recommended that the RHAs purchase services which it described as constituting an "integrated maternity services framework". The central component in this package of services was the provision of "continuity of care" for the woman and

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<sup>18</sup> The employment of this accounting firm to review maternity services and advise on service delivery options was in keeping with a trend started in the mid-1980s to avoid 'provider capture' in policy making by using independent consultants rather than advice from the medical community (see Orr, 1997: 87).

<sup>19</sup> This report did not deal with contractual arrangements or amounts to be spent. These issues, which will be discussed in the next section of this chapter, were the focus of protracted negotiations that took place between the RHAs, the NZCOM and the NZMA over implementation of the Section 51 Advice Notice of the Health and Disability Services Act 1993.

her baby by a "contracted principal practitioner".<sup>20</sup> This practitioner was to be responsible for ensuring that appropriate services were delivered, either by delivering them her/himself or by arranging with other providers to do so (Coopers and Lybrand, 1993: 28).<sup>21</sup> The identity of this practitioner (who could be an independent practitioner or an employee of a CHE or a private/voluntary group) could change as the pregnancy progressed but all such changes had to be formally agreed to and recorded.

The report identified four modules or components of care that should be included in the integrated maternity services purchased by the RHAs (Coopers and Lybrand, 1993: 33-49). These included informed choice about birth and care, pregnancy services, labour and birth services and services following birth for mother and infant. Emphasis was placed on matching services to the assessed needs of the woman, her baby and partner/whanau/family; designing services that focussed on the achievement of quality outcomes rather than the process of service delivery; providing more information to inform consumer choice; involving consumers more in service choice and offering greater continuity of care.

In promoting the concept of a primary practitioner, who provided continuity of care throughout the pregnancy, birth and postnatally, this report gave considerable support to the midwifery model of practice as the basis for contracting. This support was backed by evidence of strong consumer endorsement for this form of maternity care. For the RHAs, who were charged with purchasing the maternity services that their

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<sup>20</sup> The concept of "continuity of care" used in the report referred to an integrated service throughout pregnancy, childbirth and up to six weeks after birth. This definition was closest to that given by midwives (eg. Guilliland and Pairman, 1995). For general practitioners, continuity of care relates to family care, starting with routine general practice, moving into maternity services, and then continuing with family care. These differing understandings/claims re concepts are discussed in chapter six.

<sup>21</sup> This practitioner was identified as the individual who conducted the first long consultation which would include "an assessment of the parents' health and medical history and the current health of the woman and baby". This definition raised issues/concerns for midwives about doctors as the historical gatekeepers to maternity services.

communities wanted/needed, but also with reducing over-servicing and the escalating costs of maternity services, the shift to a modular or fixed-fee funding arrangement made sound economic sense. Confirmation from maternity/consumer groups that continuity of care throughout the maternity experience was a priority, gave the RHAs a social (as well as an economic) mandate for shifting from funding providers to purchasing services.

### **5.5 Funding Maternity Services**

The challenge of shifting to a new way of funding maternity services was initially taken up by the Health Reforms Directorate (HRD) which was set up in 1991 to establish the RHAs and develop policy advice.<sup>22</sup> The HRD funded ten primary care initiatives including the provision of a domino maternity service under a bulk-funded contract (Lovell, 1994; Middleton, 1993).<sup>23</sup> This initiative was the brainchild of a group of Wellington domino midwives who were keen to prove the cost-effectiveness of independent midwifery care. They aimed to provide a maternity service under a bulk-funded contract to approximately 180 women during 1992/1993. One purpose of the project was to develop a global fee per pregnancy for the delivery of a community based maternity service (Middleton, 1993: 1).

Midwives in this domino practice considered the funding of maternity services through the MBS to be not only extremely costly for the country but also not in the best interests of an autonomous midwifery profession (Lovell, 1994: 13). They regarded the routine payment of two providers through the MBS as supportive of doctors' continuing role as 'gatekeepers' to alternative midwifery services. Doctors could direct 'patients' to midwives in their own practices. The domino midwives believed that the funding

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<sup>22</sup> In December 1992 the HRD was disbanded and full responsibility for the projects transferred to the Department of Health.

<sup>23</sup> Another initiative involved the provision of integrated marae-based maternity and neonatal services in Papakura, South Auckland.

arrangement also meant that midwives could concentrate on the more lucrative aspects of maternity care, the labour and birth, and not provide a complete service. This fragmentation of midwifery care also contributed to doctors retaining responsibility for the provision of maternity services.

The contract that emerged after lengthy negotiations between the domino midwives and the Department of Health was closer to a cost-per-case contract than a bulk or global fee contract (Middleton, 1993: 14). This contract suited the purchaser who did not want to "pay money into a black hole" and considered that linking payment to maternity cases and gathering detailed case information was a way of auditing the quantity and quality of care undertaken. The domino midwives believed, however, that bulk funding would provide a greater incentive for continuity of care, cost-effectiveness and good outcomes. Fundamental to their concerns was the idea of a single provider managing the budget for each woman.

One factor contributing to the delay in sorting out this contract was the establishment of a tribunal to consider the scale of fees for maternity benefits. This tribunal was set up in September 1992 by Simon Upton following the NZMA's refusal to participate in negotiations over the MBS with the Department of Health and the NZCOM. Until the tribunal made its recommendations there was uncertainty as to whether doctors and midwives would continue to be paid on the same scale and what that scale would be. The HRD did not want to set up pilot contracts using fees that were higher than those recommended by the tribunal because they would become a benchmark for future contracts. On the other hand, if the fees were lower than the scale determined by the tribunal, those running the pilots would be disadvantaged (Laracy, 1.4.93).<sup>24</sup>

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<sup>24</sup> See references and appendix of information sources for details on the stories from general newspapers, magazines and professional newspapers/publications that are cited in this chapter.



The NZMA's stance in relation to the maternity benefit negotiations reflected doctors' deep-seated opposition to midwives being able to claim from the same schedule of fees. The NZMA claimed that the schedule, which was set in 1985, was based on the training that a doctor received and the range of services that a doctor provided (Malcolm, 2.7.92). According to the association chairman, Dr Alister Scott, the schedule should not be applied to midwives because they offered a "parallel maternity service". The association wanted a separate section added to the schedule for midwives. The content of this section could be negotiated between the department and the NZCOM. Scott claimed that many of the difficulties between doctors and midwives would probably disappear if there were two different schedules (Malcolm, 2.7.92).

This view was not shared by the NZCOM. The inaugural president, Karen Guilliland, described the possibility of two schedules as a retrograde step for midwifery given that it had secured pay equity in 1990 on the basis of doing exactly the same job as doctors (Malcolm, 2.7.92). While the NZCOM acknowledged that doctors and midwives worked differently, it preferred to discuss the appropriateness of the schedule in tripartite talks rather than have the expense and delay involved in a tribunal hearing. However, given the NZMA's refusal to negotiate with the college, it looked forward to having the issue of differences in approach to maternity care of doctors and midwives resolved once and for all (Laracy, 15.10.92).

These comments, taken from stories in the *New Zealand Doctor*, are examples of claims and counterclaims over maternity funding issues made by the two professional associations throughout the early 1990s. Newspapers and magazines (eg. McLoughlin, 1993; Munro, 25.6.93) recorded accusations and allegations made by doctors' and midwives' representatives about the escalating costs of maternity services, where the costs were being incurred and who was to blame. Claims were made by doctors about midwives attending labours for unnecessary lengths of time in order to claim the

generous prolonged attendance fees.<sup>25</sup> Counterclaims from midwives accused doctors of blaming midwifery for "blowing out the maternity budget" when it was largely due to their indiscriminate use of expensive technologies such as ultrasound scanning (costing \$76 a scan).

Both parties and the Department of Health put their cases to the MBS tribunal in late 1992.<sup>26</sup> While the NZMA argued for a general increase in the maternity payment and a separate schedule for midwifery, midwives sought to retain pay equity on the grounds that midwives and general practitioners provided a service for 'normal' births on their own responsibility and should be paid the same. In arguing against differential payments, the NZCOM (1992) claimed that the schedule of fees should focus on the total maternity service provided, and the outcome of that service, rather than the designation of health professionals or the location of service provision. This view was supported by the DOH (1992: 8) which said that separate fees would send signals to consumers that one health profession was intrinsically more valued than the other and that one could expect the health outcome to reflect the value of the services provided.

With regard to the fee structure, the NZMA argued (as it had in the past) against a global fee because of the need for greater financial recognition of the skills and expertise required for the safe management of the labour/delivery stage of childbirth.

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<sup>25</sup> This fee, which had been negotiated by the NZMA in the 1980s, entitled a general practitioner to claim \$139.60 per hour for attending a labour beyond the first one-and-a-half hours (for which he/she was paid a \$285 birth fee). For an independent midwife, whose practice involved attending a woman throughout her labour, entitlement to this fee generated a much higher income. For example, a midwife attending a 10 hour labour earned \$1471.60 (the \$285 birth fee plus eight and a half hours prolonged attendance fee). A general practitioner would most likely earn only \$285 for the same birth.

<sup>26</sup> A Wellington barrister, Helen Cull, led the five person tribunal. Other members included Carol Campbell, a chartered accountant from Auckland; Helen Eskett, a business advisor in a chartered accountancy practice in Christchurch; Dr Murdoch Herbert, a general practitioner/obstetrician from Auckland (the NZMA nominee) and Sally Pairman, a midwife and midwifery tutor from Dunedin (the NZCOM nominee). Pairman was the newly-elected president of the NZCOM. The NZMA was represented by Mr John Upton, QC, while the NZCOM was represented by Karen Guilliland and Steph Breen from the NZNO.

This argument was consistent with an understanding of childbirth generally, and labour in particular, as a potentially risky process requiring medical management. The NZCOM, however, agreed with the concept of a global fee because such a funding arrangement did not separate women's experiences of pregnancy and labour into various tasks or responsibilities. It was a fee structure that encouraged continuity of care throughout the various stages of childbirth. This form of care was the core component of an autonomous midwifery service.

The tribunal recommendations, which were released in January 1993, supported aspects of each profession's case. Midwives received the support they wanted for a single benefit schedule and general practitioners stood to benefit from a significant rise in the base consultation fee. The tribunal recommended that this fee (which forms the basis for other fees) rise by 26 per cent, to \$26 (Department of Health, 1993). By a majority decision, it also recommended the introduction of a \$52 an hour "conduct of labour" fee for practitioners attending a woman throughout labour. This was intended to replace the 'prolonged attendance fee' of \$139.60 an hour which practitioners had been entitled to claim for attendances beyond one-and-a-half hours. This move aimed to restore some parity between independent and hospital midwives, who earned \$15 - \$17 an hour.

The NZCOM representative on the tribunal, Sally Pairman, wrote a dissenting opinion which argued that the fee paid to midwives "must not be so low as to send signals to consumers and professionals that this work is not valued" (Pairman, 1997). Pairman feared that a low fee would make independent midwifery uneconomic and thereby reduce women's choices for maternity care. She suggested replacing the \$139.60 hourly rate with one set at four times the base fee, or \$104 under the proposed new fee schedule. The tribunal's recommendations, Pairman's dissenting opinion and further

submissions from the NZMA and the NZCOM were considered by the new Minister of Health, Bill Birch, who replaced Simon Upton in March 1993.<sup>27</sup>

To general practitioners' horror, Birch rejected the tribunal's recommendation of a 26 per cent rise in the base consultation fee in favour of a 10 per cent rise.<sup>28</sup> This made the new level \$22.70 instead of the proposed \$26. While Birch increased the birth fee to \$313.50, he further angered general practitioners by not introducing the recommended \$52 per hour conduct of labour fee. Much to the surprise of observers (McLoughlin, 1993: 60), he chose to adopt Pairman's formula. With a new base fee of \$22.70, the new hourly rate for labour care (ie. the conduct of labour fee) worked out at \$90.80. While this figure was less than that suggested by Pairman, the NZCOM was delighted that the Minister had supported the principle of pay equity and introduced fees that were substantially higher than the Tribunal had recommended.

The arguments put forward by the professional associations and the Department of Health in this dispute highlight the implications of different funding arrangements for doctors' and midwives' jurisdiction over the provision of primary maternity care. Different fee/payment structures are more suited to some forms of maternity practice than others in that they are based on different understandings about the tasks or problems involved in childbirth and how they should be addressed/funded. For example, a fee-for-service schedule with a set fee per consultation, and no limitations on the number or cost of consultations, suited the episodic form of antenatal and birthing care offered by some general practitioners. It was in these doctors' professional and financial interests for this form of funding, which enabled them to

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<sup>27</sup> Less academic and more ruthless than Upton, Birch was regarded as the toughest administrator in the Cabinet (Easton, 1994: 230) and more capable of driving home the unpopular health reforms.

<sup>28</sup> The NZMA appealed to the Ombudsman for a review of the Minister's decisions claiming that many important recommendations of the independent Maternity Benefits Tribunal had been ignored. (See Schultz, 9.6.93).

offer maternity care in conjunction with other maternity care providers (both midwives and specialists), to continue.

The fee-for-service arrangement also had some advantages for midwifery as a profession entering into a competitive market for clients. As newly independent practitioners, midwives needed time and opportunities within the market to establish their own clientele. The fee-for-service payment schedule, which reimbursed practitioners irrespective of whether they provided services independently or in collaboration with others, enabled some midwives to provide shared care with general practitioners while they built up their own caseloads. Given that payments were made at rates negotiated on the basis of doctors providing episodic maternity care, there was also an enormous financial incentive for midwives to leave hospital employment and embark on some form of independent practice.<sup>29</sup>

As independent midwifery became an established maternity care option and midwives could compete on a more even footing with general practitioners for clients, there was less need, from the point of view of some members of the profession, for a payment schedule that supported shared care. In fact, as this chapter will outline, midwifery leaders gave their support to the RHAs' introduction of a fee-per-case payment system. This support was understandable given that a global fee, paid to a practitioner who assumed responsibility for a woman's full maternity care, was more compatible with the model of independent midwifery that the NZCOM was promoting. In discouraging shared care, the fee-per-case payment system gave midwives the opportunity to secure greater jurisdiction over the provision of primary maternity services.

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<sup>29</sup> A Health Department analysis of maternity benefit claims for the 10 months to April 1993 showed that independent midwives handled 9508 births for a total payment of \$19.2 million, an average of \$2023 a birth. The five top-earning midwives were paid an average of \$203,862 each for this period. They delivered on average 104 babies at \$1960 a birth - a figure far in excess of the annual caseload of 40-60 births recommended by the NZCOM.

The new schedule of maternity fees took effect in August 1993. This was a month after the RHAs assumed responsibility for purchasing the health (including maternity) and disability services for their regions. While the MBS was replaced by the Maternity Section 51 Advice Notice of the Health and Disability Services Act (1993), providers continued to claim from the relevant RHA the same benefits they previously received from the DOH.<sup>30</sup> In addition to these payments to individual medical and midwifery practitioners, the RHAs also purchased maternity services from CHEs and a number of private provider organisations. This fragmentation of funding was identified as contributing to problems of poor access, inappropriate allocation of resources, cost shifting and poor patient management (Coopers and Lybrand, 1993: 18).

As discussed earlier, the RHAs were advised that these difficulties in the funding and provision of maternity services could be overcome by purchasing services within an "integrated maternity services framework" (Coopers and Lybrand, 1993). While the Coopers and Lybrand report laid out the key characteristics of these services - "regardless of how they are purchased, where and by whom they are delivered" - it did not deal with the contractual arrangements or amounts to be spent. This was the focus of another joint maternity project, begun early in 1994, to review the MBS and the way in which maternity service providers were funded.<sup>31</sup> A series of discussion papers was used for consultation with provider and consumer groups on proposed changes to the Maternity Section 51 Notice which governed payment arrangements between the RHAs and providers.

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<sup>30</sup> The Advice Notice is the contract which outlines the payment structure and fee schedule for primary health maternity providers. The actual payment for services is made by Health Benefits Limited (HBL), a company formed by the four RHAs.

<sup>31</sup> Policy guidelines for RHA purchasing, released by the Government in March 1994, advised them to develop proposals to replace Section 51 notices when they expired. The Government expected RHAs to use a variety of approaches to contracting with general practitioners, including budget-holding. Guilliland said (Interview: 15.6.96) that the NZCOM had been told in the early stages that Section 51 was just transitory and the movement was towards a variety of contractual arrangements.

## 5.6 Negotiating Section 51

Negotiations between the RHAs and the various provider associations, consumer groups and CHE representatives over the structure and funding of the new maternity system were protracted, controversial and, at times, highly acrimonious. Interprofessional conflict was aired in the public arena with highly publicised claims and counterclaims about different aspects of medical and midwifery approaches to maternity care. Headlines such as 'Birthing Wars', 'Victims of specialists' squabble', 'How mothers coped in no-man's land', 'Freedom of choice is one of the casualties as snipers take aim' (Hollings 21.11.94, 14.12.94) drew newspaper readers' attention to the "dangerous tug-of-war" raging between specialists, general practitioners and midwives. These articles highlighted cases where problems of communication between doctors and independent midwives had resulted in birth injuries to mothers or babies.<sup>32</sup>

Stories that appeared in the *New Zealand Herald* in January 1995 showed that this 'war' was one of words as well as of practices. An Auckland general practitioner, who was also a member of the medical practitioners' disciplinary committee, wrote an article in which he claimed that midwives, whom he described as a "new birth lobby", preached "active inactivity" in childbirth (Sutherland, 3.1.95; Ferguson, 3.1.95). Dr Allan Sutherland claimed that midwives argued against the use of such developments as foetal monitoring, blood sampling and ultra-sonography because they rendered a birth "not normal" or "unnatural". His claim that babies were dying or being injured through lack of proper medical care during birth was backed by the president of the Royal New Zealand College of Obstetrics and Gynaecology, Dr Tony Baird.<sup>33</sup>

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<sup>32</sup> This image of warfare between the professional groups was also evident in the Coopers and Lybrand report which undertook a national consultation process and noted (1993: 45) that participants, especially consumers, described current birthing practices as a "battleground" with providers fighting for their particular way of doing things.

<sup>33</sup> Both these doctors aired similar views in an article in *North and South* (McLoughlin, 1993) on the politics of childbirth. Their argument was supported by an obstetrician from

In an article outlining the NZCOM response, national coordinator Karen Guilliland (*New Zealand Herald*, 26.1.95) dismissed the doctors' claims re baby deaths as not being supported by the evidence. She pointed to the 1992 and 1993 annual reports of National Women's Hospital which showed the continued decline in perinatal mortality.<sup>34</sup> Guilliland questioned medicine's assumption that interventions such as routine foetal monitoring and cutting of the birth canal improved the outcome for the baby. She said it had been shown that "mindless activities" such as the routine use of technologies at best made no difference to the outcome and, at worst, could increase the risk for the woman and/or baby.

Despite the RHAs' intention of having the proposed new maternity contracting arrangements in place within a year, negotiations over the service specifications and payment mechanism continued for two and a half years. Central to the discussions was the RHAs intention to purchase maternity services as a series of modules of care rather than single service episodes which were paid for separately. This involved shifting from a fee-for-service to a fee-per-case, modular payment system. This shift was not confined to the provision of maternity services as the RHAs were involved in negotiations with general practitioners over the introduction of budget-holding contracts for a range of primary services including laboratory tests and pharmaceuticals.

This move was again similar to changes being implemented in Britain and other western countries to provide practitioners with a financial incentive for containing spending on primary health services (Ham, 1997; Klein, 1995; Stuart, 6.4.94). Budget or fund

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Thames, Christopher Harrison, who wrote an article in which he claimed that obstetrics was being left in the hands of midwives with specialists acting mainly in a "rescue or consultative mode". He claimed (Harrison, 18.1.95) that obstetricians regarded childbirth as a "natural event" but advocated careful monitoring during pregnancy and intensive care during labour to deal with the many emergencies that may arise.

<sup>34</sup> Such statistics are cited because Aotearoa/New Zealand does not have a national perinatal database - despite widespread recognition of the need for such information.



holding in the UK involved general practitioners managing a budget on behalf of their patients for primary care, diagnostic services, pharmaceuticals, some secondary care and specialist referrals (not maternity care). In the British situation, there was no financial risk to the general practitioner as the emphasis was on budget-holding for secondary services. Despite this safeguard, there was intense opposition to the introduction of budget-holding as an option for managing care from general practitioners who feared that the Government's hidden agenda was to cap primary health care spending.

General practitioners in Aotearoa/New Zealand were concerned that budget-holding would lead to the transfer of financial risk from the Government to the provider and the possibility of under-servicing (Turnbull, Simon and Tracey, 15.2.95). Examples of the latter included general practitioners not doing important tests, choosing an inferior medicine, not asking for a second opinion or avoiding treating patients either with chronic medical problems or requiring expensive surgical treatment. Despite these concerns, in late 1994 the RNZGP gave cautious endorsement to budget-holding as one means of funding primary health care. The college noted that managed care organisations were more likely than individual doctors to take on the financial risk involved in budget-holding and may be prepared to develop performance-based bonuses for general practitioners working within their organisations.<sup>35</sup>

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<sup>35</sup> While the general budget-holding contracts were being negotiated, the RHAs were entering into other contracts with groups of practitioners in their regions. The majority of primary care contracts were negotiated with independent practitioner associations (IPAs) which held the budget for the care either provided by, or sub-contracted out by, its practitioner members. For example, a Christchurch IPA representing 180 general practitioners (Pegasus Medical Group) signed a contract with the Southern RHA in November 1993 which included fundholding for laboratory services for 40 of its members. Under the terms of this contract, the general practitioners continued to set their own patient fees and receive GMS and other subsidies and payments at the same level as under the old system. Pegasus met the cost of these claims and was reimbursed by the RHA. Any savings made by the IPA would be put back into patient services.

The first two years of Section 51 consultation were spent on refining the service specifications of each aspect of the service, and in particular the role of the lead maternity carer (LMC). This concept was introduced in Draft Three (Joint RHA S51 Maternity Review Project, 1995: 6) to identify the practitioner chosen by the pregnant woman to take responsibility for services related to the assessment and monitoring of her pregnancy, birth and postnatal care. The LMC, who was either a midwife, a general practitioner or an obstetrician, would not necessarily provide all services themselves but would be "expected to take an active part in managing the labour and birth".<sup>36</sup> The draft noted that continuity of care by the LMC was highly desirable and it was expected that in most cases the various modules would be provided by the same health professional.

These modules were designed to incorporate care from the second trimester (13-27 weeks after conception) through to 28 days after the birth, with payment being based on each of the five modules.<sup>37</sup> The service specifications attached to each module describe the type, rather than the quantity, of services to be provided. This was due to the RHAs' belief that health professionals working with each woman are best able to determine this on a case by case basis (Joint RHA S51 Maternity Review Project, 1995: 9).<sup>38</sup> The fee paid for each module includes all aspects of the specified care. Where an

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<sup>36</sup> The RHAs agreed that an organisation such as a CHE or an Independent Practitioner Association (IPA) was not able to claim payment for primary maternity services via a Section 51 Notice. Other contracting options, incorporating most of the terms of Section 51, had to be negotiated between these organisations and the appropriate RHA. Where an organisation obtains such a contract, a suitably qualified and experienced LMC has to be allocated to a woman requiring maternity care. The significance of this was that secondary care institutions like CHEs could reorganise their services in such a way as to compete with primary maternity providers for clients (as discussed in chapters seven and eight). It also encouraged the formation of group/team contracts which enabled both general practitioners and midwives to opt out of the collective, national section 51 agreement in favour of other payment arrangements.

<sup>37</sup> A copy of the Maternity Payment Schedule (MPS) is included in the appendix. Professional services for the first trimester (1-12 weeks after conception) are paid on a fee-for-service basis. The module payments include \$165 for second trimester (13-28 weeks), \$230 for third trimester (29 weeks-labour), \$950 for labour and birth (for a first birth) or \$750 for labour and birth (subsequent births), and \$280 for postnatal care (where the woman is an inpatient) or \$380 for postnatal care (where the woman is at home).

<sup>38</sup> The RHAs expected the LMCs to manage their services in such a way as to provide what was appropriate for each client. They recognised that some women would have greater needs than others but it was up to the health professionals to "manage the swings and

LMC subcontracts another health professional to perform some of the service, she/he is required to pay for that care out of the module fee. Thus the system involves the LMC holding the budget for various components of a client's maternity care.<sup>39</sup>

Of particular concern to the general practitioners was the RHAs proposal to introduce budget-holding for labour and the puerperium. Previous to the final draft of the Section 51 proposals, there was a fee for labour care and a separate fee for midwifery care. The introduction of a single fee, which was based on the average cost of one attendant during labour, was obviously a disincentive for involving two caregivers in labour. However, where two practitioners were involved, it was up to the LMC to pay for the services of the other health professional out of the labour fee. The NZMA was concerned that this arrangement would enable the LMC to split the fee with other health professionals "as they saw fit" (Tyler, 14.6.95). It urged the RHAs to specify what the midwifery fee for labour should be.

When the module fees were made public in June 1995 there was considerable opposition from both health professionals and maternity consumer representatives (Tyler, 26.7.95, 16.8.95; Gilling, 17.7.95). The NZMA and the NZCOM argued that the budget levels were set at minimum levels of care. The fees that provoked most concern were those attached to the labour/birth and postnatal modules. The labour/birth fee was \$750 and made no allowance for whether a woman was having her first or subsequent baby. This module was considered to be grossly underfunded, particularly given that it included the cost of midwifery care. The postnatal module fee was \$350, with an extra \$80 allocated for women who left hospital early. Out of this fee the LMC was expected to pay for postnatal midwifery care provided by CHE staff.

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roundabouts themselves". All situations that fell outside of "normal maternity conditions", including women with special needs and those requiring specialist care, would be provided for in individual contracts between the separate RHAs and health providers.

<sup>39</sup> The RHAs estimated that a normal birth, without specialist care costs and including a hospital stay, came to between \$1600 and \$2000.

General practice and midwifery representatives argued that the proposals were a "cost-cutting exercise" designed to reduce the maternity service. They claimed that underfunding would put women's choices and safety in jeopardy and make co-operative care difficult to achieve. In a rare show of unity, they argued that a woman's ability to choose care from a doctor and a midwife would be under threat under the RHA proposals because the practitioners would not be able to afford to provide such a "comprehensive and co-operative service". In contrast to its earlier position (in the MBS Tribunal negotiations) on shared care as over-servicing, the NZMA claimed that there should be a doctor and a midwife at every birth as it was the safest option.

The RHAs met with the provider associations in July 1995 to discuss the fee rates. Following these meetings recognition was given to the increased time involved in providing labour care for a woman having her first baby and the labour/birth module fee for these women was raised to \$950. However, this increase came at the expense of the postnatal module fee which was reduced to \$200. The NZCOM and maternity consumer groups were highly critical of the postnatal module being reduced - claiming that it was inadequate for the follow-up community support that midwives provide in home visits. In a revised draft of the fees, issued in December 1995, the postnatal module was increased to \$280 if a woman received inpatient postnatal care or \$380 if she did not. The NZCOM considered this increase inadequate and continued negotiating for extra funding (Guilliland, 1996).

By early 1996 both the NZCOM and the NZMA were still unhappy with various aspects of the RHAs latest draft Section 51 Notice. While the midwives' concern focused on the resourcing of postnatal and rural maternity services, the NZMA was critical of more fundamental aspects of the proposed new arrangements. In a letter to the four RHAs, the association requested discussions over the possibility of

introducing a complexity payment for general practitioners with additional obstetric skills. It argued that this payment would compensate those general practitioners with the skills to provide care in cases where midwives referred clients on to secondary services. According to the NZMA, this complexity fee could be funded out of a percentage of the module payments.

The NZMA proposal was not supported by either the RHAs or the NZCOM. The college detailed midwives' complexity issues and argued that these were accommodated within the 'swings and roundabouts' philosophy of the modular payment system (Abel, 1997). The college argued that the doctors' proposals would reduce the maternity care options available to women. It threatened to take legal action against the proposals on the grounds that they were tantamount to price-fixing and directly contravened the funding arrangements that had been agreed to during the consultation process (Tyler, 31.7.96). The RHAs agreed with the college that the NZMA proposal contravened the basic principles of the module system and suggested that the proposed structure should remain as it was.

General practitioners' dissatisfaction with the controversial maternity notice intensified over the last few months before it was formally issued. In June 1996 the NZMA issued a special alert - a "Red Letter" - to all doctors outlining its concerns about the quality and safety of maternity services under the new scheme. Newspapers throughout the country reported on meetings called by doctors' groups to oppose the RHAs' proposals.<sup>40</sup> In Christchurch, doctors expressed their opposition to the new maternity scheme by publishing two open-letters to the women of Canterbury in the morning newspaper, *The Press* (29.6.96).<sup>41</sup> In strongly emotive language, the letter from

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<sup>40</sup> By late June NZMA branches in Auckland, Northland, Waikato, Rotorua, Taupo, Tokoroa, Hawke's Bay, Palmerston North, Feilding, Wairarapa, Nelson, Blenheim, Christchurch, Dunedin, Oamaru, Balclutha, Palmerston, Mosgiel and Invercargill had rejected the new maternity scheme (Eden, 28.6.96; Chisholm, 7.7.96).

<sup>41</sup> These half page letters, one from general practitioners and allied specialists (153 signatories) and the other from specialist obstetricians (12 signatories), were accompanied

general practitioners and allied specialists warned women that they may become involved in an "unfortunate experiment" which would reduce their choice of, and access to, safe maternity care.<sup>42</sup> It described the new arrangements as "scandalous and insulting" and "belittling of the value of all women".

At a series of meetings organised by the Southern RHA in June to explain the new funding arrangements to providers, general practitioners and specialists were particularly vocal in their opposition to the changes. At one meeting a tearful general practitioner said the Section 51 document was based on the false premise that the services provided by general practitioners and midwives were the same. She felt the differences between the two specialties were being "fudged" in the notion of an LMC and the intention to pay for services in the same way. While the RHAs were arguing for choice for women, in her view they were "killing" women's choice.

Shared care is an important option for women which needs to be provided in a flexible way that is accommodated by fee-for-service. With a modular payment system it goes out the window. You say we can subcontract but I am sorry it is not going to happen - and it is very sad (Christchurch GP: 14.6.96)

Despite an appeal from the NZMA to roll over the existing payment arrangements and continue with negotiations, the new Section 51 Notice took effect from 1 July. The RHAs ran newspaper advertisements, distributed information leaflets and set up a toll-free hotline to explain the new options available for maternity care and assure women that the services would continue to be provided free of charge. With threats from the NZMA that doctors would boycott the new arrangements and bill their patients for care

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by a half-page 'advertisement' from the NZMA urging pregnant women to discuss their maternity care options with their doctors first.

<sup>42</sup> The doctors' use of the term "unfortunate experiment" was an attempt to gain impact by linking the new maternity arrangements with the biggest medical/health scandal to occur in Aotearoa/New Zealand (as discussed in chapter three). The doctors' strategy was to highlight the fact that the system had not been trialled in any region before being introduced on a national basis and, from their perspective, could reduce women's access to safe services.

(Chisholm, 23.6.96; Bailey, 26.6.96; Cannan, 27.6.96;), the RHAs were largely relying on the support of independent midwives to show that the new maternity system was not only workable but also in the interests of pregnant women and their families.

## 5.7 Implementing Section 51

The controversial new maternity scheme arrived with a blaze of publicity (eg. Maling, 26.6.96; Eden, 28.6.96; Barber, 3.7.96). Prominent in the headlines was the decision by many general practitioners throughout the country to boycott the new arrangements by not claiming under the Section 51 Notice for the antenatal care that they provided (Bailey, 1.7.96; Heenan, 2.7.96; Laxon, 3.7.96; Wright, 24.7.96). Many of these general practitioners deferred claiming and carried the costs from their general practice income in the hope that there would soon be a resolution to the dispute.<sup>43</sup> General practitioner representatives even went as far as advising couples contemplating parenthood to "wait a month or two" before conceiving so as not to be caught up in the controversy over maternity payments (Chisholm, 7.7.96).

Within weeks of the new Section 51 Notice taking effect, an alternative scheme was proposed by a Joint Maternity Working Party representing various medical interests.<sup>44</sup> This scheme, which aimed to reinstate fee-for-service but within capped budgets, was designed to retain the shared-care arrangements that doctors considered would be lost under the RHAs' plan (Tyler, 24.7.96; Coster, 28.8.96; Coney, 1.9.96). It reduced the

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<sup>43</sup> A legal dispute ensued over whether general practitioners who did not want to work under the new system could legally charge for maternity services. The RHAs said that general practitioners who had been claiming under the old system could not legally charge under the new system unless they had formally advised the RHA in writing that they would not be providing any publicly-funded maternity services. The NZMA's legal opinion was that general practitioners who did not claim under the new maternity notice could charge patients for maternity care. The GP Action group advised general practitioners to charge their pregnant patients the range of fees in the 1993 Section 51 document hoping that this would force the RHAs, who were committed to providing free maternity services, to make changes to the system.

<sup>44</sup> This group consisted of representatives of the NZMA, the General Practitioners Association, the RNZCOG, the RNZCGP the Rural GP Network and the GP Action group.

budget for labour and birth for first births and took money out of the arguably inadequate postnatal budget. Under the doctors' proposal, postnatal care would be paid for at \$28 a visit to a maximum of \$336 for a first-time mother and \$196 for subsequent births. Under the modular payment system, the postnatal fee was \$380 for all mothers. The doctors' scheme also allowed for claims by providers other than just the LMC.

While general practitioners and specialists pursued various means of opposing the new maternity arrangements, the NZCOM urged its members to take advantage of the opportunities that now existed for both women and midwives. Despite its concerns re the funding of postnatal care and rural maternity services, the college continued to be involved in negotiations with the RHAs because it supported the philosophy underpinning the changes. As college president Sally Pairman explained, in a letter to the editor in the *Otago Daily Times* (5.7.96), the college regarded the new service as being underpinned by the principles of continuity of care, choice for women and informed decision making. It supported the RHAs determination to establish a maternity system which identified the kind of service women should expect and made providers accountable for their services. In defence of the new system, and midwifery's qualified support for it, Pairman wrote:

There is much of benefit in the new system and its most radical change is the shift in power and control from doctors and midwives into the hands of women. Perhaps this is what upsets the doctors. That, along with the decision by the RHAs to stop the double and treble payments they have been making for maternity care in the past. Now providers will have to sit down and talk to each other, work out what each contributes to the overall service for a particular woman and negotiate payment for this with each other. Scary stuff for health professionals who have been used to unquestioning payment on demand from the government.

NZCOM leaders were anxious that midwives, who may be tempted to opt out of Section 51 in favour of group or 'team' contracts, understood the benefits to the



profession that it offered. In a speech to delegates at the college's national conference in August, national director Karen Guilliland (1996) said the Section 51 framework had the potential to empower women and protect the autonomous role of the midwife. She pointed out that it was a collective, nationally agreed contract which was the foundation of all other contracts negotiated with smaller groups of midwives including those providing CHE midwifery services. It was, she said, the collective and combined professional strength offered by the Section 51 contract that gave midwifery its negotiating power.

Most midwives are not yet strong enough to guarantee that negotiating power when fragmented into multi-disciplinary groups. Neither is society ready to fully stand behind our embattled profession (Guilliland, 1996: 3).

In her typically forthright and challenging style, Guilliland questioned whether some midwives understood or even wanted the responsibility that the Nurses Amendment Act placed on them to practice autonomously. Some midwives, she claimed, did not understand that to be autonomous did not exclude working with others and had construed it to mean practising in isolation.

Others understand all right but have opted out of their obligations in favour of a dependent, and in their view, less threatening role (Not true - shared care is much more threatening for you and women). Not one of these midwives have, however, opted out of the payment or status rewards an autonomous profession brings to them. A few have actually abused that privileged societal position (Guilliland, 1996: 7).

Guilliland described as "disheartening" the ease with which some midwives accepted the doctors' position and used it against their own profession. Some midwives, she said, had joined doctor groups and publicly disassociated themselves from their

colleagues and the college's stance.<sup>45</sup> No doctors, she pointed out, had undermined their profession's public position in this manner.

While there is no need or place for all midwives to agree, there are principles at stake here which hold the key to midwives' survival and our professional integrity protected (sic). For any midwife to believe that the medical profession has the interests of midwives at heart more than midwifery's professional body, is an astonishingly naive display of oppressed group behaviour (Guilliland, 1996: 7-8).

This address, which ended with an inspiring excerpt from Nelson Mandela's 1994 inaugural speech, highlights how critical a time mid-1996 was for midwifery as an autonomous profession. Practitioners were confronted with changes in the system of providing and funding maternity services that, on the one hand, offered new opportunities to consolidate their position as autonomous providers of primary maternity care but, on the other hand, provided a means to curtail their independence. If significant numbers of midwives opted out of Section 51 and into team/managed care contracts, in which doctors were the gatekeepers to maternity services, then the likelihood of midwifery surviving as an autonomous profession would have been seriously reduced.<sup>46</sup>

The possibility that midwives might think they had little option but to join doctors and other health professionals (including chemists and nurses) in IPA negotiated contracts, had prompted the NZCOM to investigate the feasibility of establishing regional

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<sup>45</sup> Guilliland was referring to a group of six midwives in the Wairarapa who spoke out against the college's position in defending their decision to support local doctors in a team contract for maternity services.

<sup>46</sup> In an interview in mid-June for this research project, Guilliland said her task was to "take the panic out of the change" by going on a whistle-stop tour of the country to explain to midwives the principles underpinning Section 51. "... so they understand what it is that they've got before they give it away. If they choose to give it away that is their choice - I'm not going to spend anymore sleepless nights worrying about people being cohesive. I feel that what we've achieved here is so phenomenal that if the midwives can't see that and actually want to give it away then we don't have a movement at all. We just have a few core people who had some sort of vision. If they decide they'll sell out and go and pool with the doctors and get shared care back then so be it".

midwifery provider organisations (MPOs). An Auckland-based working group, set up to examine the feasibility of establishing a midwifery contracting organisation in the Northern RHA area, found that there was strong support for the initiative from independent midwives (MPO Feasibility Report, 1995). It recommended that the RHA provided financial assistance, which was commensurate with that given to medical IPAs, to facilitate the establishment of a MPO. The MPO would then contract with the RHA for the provision of midwifery services in the northern region.

Representatives of the NZCOM in the Canterbury region pursued a different strategy. In response to an indication from the Southern RHA that it would look favourably on a joint midwifery/medicine contract, midwives endeavoured to set up an IPO (called Midwife Maternity Services) and engaged in negotiations with the Pegasus Medical Group over the formation of a combined contracting organisation. The objective was to form a joint company (or trust/society) which would be run by a board of trustees representing Pegasus and the midwifery IPO. This organisation would then contract with the Southern RHA on behalf of its midwife and general practitioner members for the provision of primary maternity services in Canterbury. Like other large provider organisations, it would relieve individual practitioners from carrying the financial risk associated with the bulk funding of services.

What the general practitioners and midwives had not anticipated was being asked by the RHA to assume responsibility for managing the \$4 million primary maternity budget for Christchurch. According to the national director of the NZCOM, Karen Guilliland, neither the midwives nor the general practitioners were prepared to take on the financial risk associated with such a move (Interview: 19.12.95). While neither provider group would agree to the SRHA proposal, they recognised the value of working together at a political level and continued trying to secure a more "palatable" arrangement with the RHA. By mid 1996, however, midwifery representatives had more interest in making

the most of opportunities available through the national Section 51 maternity funding contract than pursuing the establishment of new contracting organisations or arrangements.

In an interview in mid-June for this project, national director of the NZCOM Karen Guilliland outlined why the college had looked at setting up MPOs and why the initiative was effectively on hold.

While we were negotiating Section 51 we had a whole lot of people who were busily wanting to go off and contract in different ways to provide services and the RHAs were actually pushing that initially... So in order to confine that - or to make those people feel that the ability to meet their individual needs was there - we started the process of setting up midwifery provider organisations.

But in actual fact it has always been a stalling process. We didn't know which direction the Government was going to go in. We didn't know the direction the RHAs were going in. We didn't really know which direction we wanted to go in. Because of the overall changes in the health reforms everything was fairly unsettled about what would be the best thing to do. Given that the doctors had IPAs and were looking like they were getting funds - it seemed to us that we needed to do that.

But the longer we looked at MPOs and the better we got with our negotiating of Section 51 - and the more addicted the RHAs became to Section 51 - the less important were the MPOs. Over the last six months it would be reasonably fair to say that most of us involved see the MPOs as just an empty vessel sitting there - it's useful to refer to, it shows we're ready, it's a framework if we do need it (Guilliland, Interview: 15.6.96).

A key reason why the NZCOM favoured the Section 51 funding arrangement over fundholding by a provider organisation was that it made the individual practitioner more financially accountable to the client. Guilliland acknowledged that it was hard to monitor and keep practitioners providing quality services. The college believed that it would be more difficult for a midwife to "rip somebody off" if she was the LMC and

was personally responsible for, and accountable to, the client than if she worked for a cartel. According to Guilliland: 'It doesn't matter that the cartel is made up of midwives - it is ultimately a business - and that is the way of the world' (Interview: 15.6.96).

For those independent midwives who were providing mostly midwifery-only care, the general practitioners' boycott of the new arrangements created new opportunities for promoting themselves as LMCs.<sup>47</sup> Their efforts were assisted by publicity given to the trial of budget-holding by domino midwives in Wellington which noted how successful the scheme had been (Maling, 3.7.96). According to the report, there had been no difficulties with subcontracting a doctor to provide shared care for the small percentage of clients who wanted it. Neither had there been any difficulties in consulting with local specialists when complications occurred. The modular payment system had enabled the midwives to spend more time with women when they needed it because payment was spread over the entire pregnancy instead of being concentrated on labour and birth.

Another outcome of the general practitioners' boycott of the new maternity system was that more women seeking maternity care began looking to services provided by medical and midwifery staff in maternity hospitals. Given a decline in the number of general practitioners offering maternity care, particularly antenatal services, there was concern that greater demand would be placed on base maternity hospitals, like Auckland's National Women's Hospital. The hospital's senior medical adviser, Dr Tony Baird, warned that the hospital would not be able to cope with the increased demand and standards of care would be compromised (Tyler, 28.8.96). Contrary to Dr Baird's warning, this demand from pregnant women for maternity care provided by hospital-

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<sup>47</sup> A large advertisement in the *Otago Daily Times* (3.7.96) featured photographs of fifteen independent midwives who were not going to allow the "administrative tangle" in the new maternity arrangements to affect their provision of free maternity services to women. The advertisement stated that midwives as LMCs offer a special bond - "sharing your entire birthing experience and supporting you through it".

based medical and midwifery staff was to prove to be of considerable advantage to CHEs looking to compete against other providers for a share of the primary maternity market.<sup>48</sup>

For those general practitioners whose involvement in maternity care was threatened by the modular payment/Section 51 arrangements, the entry of some CHEs into the market as primary care providers was the last straw. Under the new competitive contracting model, CHEs could access funding for the provision of primary maternity services (approximately \$90 million) that was previously available only to independent practitioners, ie. general practitioners, obstetricians and midwives, through the MBS. With restrictions being placed on their secondary-care budgets, there was a financial incentive for some CHEs to reorganise their services to capture both a share of the primary maternity market and RHA funding.

According to Dr Anton Wiles, the deputy chairperson of the NZMA, many general practitioners were giving up maternity work because of the difficulties they were experiencing now that hospitals were competitive providers. In an interview on National Radio (11.2.97), he said that general practitioners were fed up with the restrictions placed on their maternity practice by the new system and the way they were being treated by the CHEs. He believed that independent midwives and doctors could have worked out a system - "a truce or whatever you would like to call it" - where they had their own areas of practice. However, it was the way that hospitals had come into the system that had really "mucked it up". Of particular concern to general practitioners was the way that some CHEs were taking over the provision of a woman's labour and birthing care, and collecting the funding for that module, despite the doctor being her LMC.

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<sup>48</sup> The development of new forms of CHE-based primary maternity care is the focus of chapter seven.

A doctor (GP or specialist) has to employ a midwife and we agree with that. We were told right at the start that the hospitals would have a fixed fee for providing a basic level of midwifery services. There is not a hospital in the country that agrees with the fee that the RHAs set. Now we have hospitals that say that a GP looking after their own patient can do so until the lady goes into labour and then the best option they have - to have any hospital involvement - is for the hospital to take over the patient while she starts in labour - looks after her while in labour - and hands her back when she's had her baby and takes all the money. Now the GP can come along to the delivery if he/she likes but they won't be paid. That's the extreme that has been happening in several hospitals around the country (Wiles, National Radio Interview: 11.2.97).

The depth of general practitioner frustration with the new maternity system and their treatment by CHEs was highlighted by the withdrawal, in February 1997, of Tokoroa's ten general practitioners from the provision of obstetric care. The general practitioners in this small North Island town handed in their notice to discontinue providing obstetric services after the local CHE offered them \$150 per delivery out of the \$750 budget (Wenley, 19.2.96).<sup>49</sup> The NZMA estimated that there had been a 50 per cent drop in the number of general practitioners providing obstetric care since 1995 (Ansley, 1997; Legat, 1997). The number of general practitioners offering obstetrics remained highest in Wellington and Christchurch where special contracts were in place that meant that doctors were still paid about \$1000 a delivery. In these cities the RHAs contracted separately with large independent provider groups for the provision of a range of primary pregnancy/birthing services.<sup>50</sup>

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<sup>49</sup> General practitioners in Tauranga had also withdrawn their services because of the steep fees they were being charged by the CHE, Western Bay Health, for midwifery services (Tyler, 30.10.96). For a first baby, general practitioners were charged \$550 for midwifery care during deliveries - out of a module fee of \$950. For second and subsequent deliveries, they were charged \$450 - out of a module fee of \$750. According to the CHE, the high fees were set by the local independent midwives who were providing care during deliveries. A spokesperson claimed that the CHE had attempted to mediate between the midwives and the general practitioners to help come up with a fee that would suit both parties but the midwives were "demanding the lion's share of the delivery fees" and there was nothing that the CHE or general practitioners could do.

<sup>50</sup> The Central RHA signed a contract with Matpro, a company involving more than 100 Wellington general practitioners, obstetricians and midwives, in September 1996. This contract was consistent with the national maternity arrangements re the choosing of an

By mid-1997 it was evident that general practitioners' attempts to reintroduce fee-for-service, but within capped budgets, was not going to be supported by the NZCOM or the RHAs. In fact, the college threatened to take legal action if the RHAs accepted the doctors' proposal claiming that it would not only reduce the maternity care options available to women but also ensure that doctors would be consulted for every pregnancy (Vasil, 23.7.96). After further negotiations, the RHAs proposed a number of amendments to the Section 51 Notice which it believed addressed a significant number of practitioner issues. These included the removal of ultrasound scans from budget-holding, increases in the labour and birth fee, separation of the CHE midwifery fee and introduction of separate fees for the six-week check of the mother and baby.

General practitioners' groups described these proposed amendments as cosmetic and unlikely to encourage the remaining doctors to continue to provide maternity services (*New Zealand Doctor*, 15.10.97). The general practitioners remained opposed to the capped modular fee structure on the grounds that budget-holding for individual patients within such tight monetary constraints was unethical. They argued that general practitioners were being left with the "at-risk" area of urgent antenatal visits and postnatal checks with reduced amounts payable for miscarriage attendance and maternal postnatal checks. They were also angered by the fact that there was no recognition or extra financial reward for general practitioners who continued to provide care even where it was easier to transfer to another provider.<sup>51</sup>

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LMC but involved the group, rather than the individual practitioner, holding the budget (Maling, 24.6.96; Swain, 2.9.96). As a consequence of this contract, and a review of services provided at the CHE Capital Coast Health, the hospital withdrew from providing primary maternity care.

<sup>51</sup> The exodus of general practitioners from maternity work continued over the next 18 months. Figures released by Health Benefits Limited showed that there were 845 general practitioners registered as LMCs between July and September 1997 and 451 for the same period in 1998 (*The Press*, 2.11.98).



A press release issued by the NZMA in October 1997 claiming that the newly formed Transitional Health Authority (THA) was considering ditching the maternity arrangements and recommencing negotiations was denied by the national maternity services co-ordinator, Bruce Rogan.<sup>52</sup> In an interview on National Radio (17.10.97), Rogan said that the THA's priority was to get the Section 51 Notice finalised. If the maternity system could be stabilised - "with everybody working amicably" - then the THA would be willing to receive joint, collaborative submissions from the various parties about how to proceed. Rogan agreed with the interviewer that some of the anxiety about the maternity system had been generated by "self-interested exaggeration" on the part of the professional associations.

One does actually have to start asking who is concerned about women and their well-being in all this. (Answer?) ... the consumer groups are probably very concerned about it, we are genuinely concerned about it and individual practitioners are concerned about it but some of the spokespeople are advancing agendas that possibly aren't as consumer focussed as they ought to be (Rogan, Interview National Radio, 17.10.97).

## **5.8 Jurisdiction, the state and the market**

This account of the complex negotiations that took place between midwives, doctors and state actors/managers over the funding of maternity services highlights the significance of these arrangements for how the professions fared in the struggle for jurisdiction. As this chapter shows, the specifics of particular payment systems have important implications in terms of the opportunities available to midwifery and medicine to either defend and/or extend their jurisdiction or control over the provision of maternity services. In highlighting the significance of the various funding regimes, this chapter presents further evidence of the crucial role played by the state in enhancing or

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<sup>52</sup> The THA was formed following the decision (by Health Minister Bill English) to amalgamate the four RHAs into a single purchasing authority. The THA, which came into being on July 1, 1997 became the Health Funding Authority (HFA) in October 1998.

diminishing the jurisdiction that professions have at any given time over the provision of particular 'expert' services.

Under the fee-for-service payment system, which was in place when midwives were given the right to practice independently, both professions potentially had the opportunity to enhance their jurisdictions. For general practitioners who were providing antenatal and/or birthing care, there was the advantage of being able to work in close collaboration with independent midwives rather than relying on the services of CHE midwives. For those general practitioners who did not offer maternity services, the establishment of independent midwifery as a maternity option meant that patients were less likely to go to another doctor for their maternity and, more importantly, subsequent family health care. For newly independent midwives, there was the opportunity to provide shared care with general practitioners while they built up their caseloads and their confidence as autonomous practitioners.

While fee-for-service meant that both doctors and independent midwives were reimbursed for whatever services they provided, there was still intense competition for clientele within the limited primary maternity care market. This competition fuelled increasingly acrimonious jurisdictional disputes over the distinctiveness and desirability of each profession's approach to the provision of maternity services. Central to these disputes were differing claims about what pregnancy and childbirth involved and the expertise required to provide appropriate care. While doctors emphasised potential risks and argued for greater financial recognition of the medical knowledge and skill needed to ensure a safe outcome, midwives sought to consolidate their jurisdiction over childbirth as a normal, physiological process.

While this competitive situation encouraged practitioners to provide flexible and consumer-oriented services, there was no incentive for them to ensure that these

services were cost-effective. In fact, the fee-for-service payment system not only enabled practitioners to provide the more costly option of shared or dual care but, without a capped budget, it also encouraged the over-servicing of clients. Faced with the need to contain the cost of primary maternity services, and to resolve some of the highly publicised problems arising out of the interprofessional struggle for greater jurisdiction over childbirth, the state had little option but to introduce a new method of paying for these publicly-funded services.

The state's response, which was in keeping with other cost-containing strategies it had adopted in the health sector, was to shift to a fee-per-case, modular payment system in which a contracted practitioner (LMC) effectively held the budget for a client's care. While such a system did not preclude shared care, it made it a much less attractive option both financially and professionally for a lot of practitioners. In basing shared care on a contractor/subcontractor relationship, the new payment system required doctors and midwives to negotiate the terms and the costs/value of their respective input into a client's care. It therefore demanded greater collaboration, over clinical and financial issues, from independent practitioners who were also competitors for primary maternity clients.

The introduction of a payment system which discouraged shared care was particularly problematic for doctors because their maternity practice relied on supplementary care being provided, especially during labour and birth, by either independent or CHE-based midwives. While doctors did not incur any cost for the provision of midwifery care under the fee-for-service system, the Section 51 maternity notice required that they, as LMCs, had to pay for this care out of the fixed labour/birth module fee. Given doctors' dissatisfaction with the fee levels, and their inability to control the cost of midwifery services, it was not surprising that many withdrew from providing maternity care under the national contract. For doctors who provided maternity care through

IPOs, there was less concern about the financial risks involved in budget-holding because the organisation, rather than the individual practitioner, held the budget.

For midwifery, the implementation of a funding regime which discouraged general practitioners in particular from offering maternity care was obviously of professional advantage. Without shared care as a readily-available maternity option, there was more opportunity for both midwives and birthing women to opt for midwife-only care. It was on this model of independent practice, in which a midwife assumed responsibility for providing a woman's full maternity care, that midwifery based its claim to autonomous status. With the introduction of a payment system that encouraged both CHE and community-based midwives to provide independent care, midwifery had an opportunity to extend/consolidate its jurisdiction over the provision of primary maternity services.

From this discussion of the implications for general practitioners and midwives of shifting from one method of funding public maternity services to another, it is evident that the state plays a major role in shaping their opportunities to defend and/or extend their professional jurisdiction over these services. In implementing a funding regime that was more compatible with autonomous midwifery practice than the episodic type of maternity care offered by general practitioners, state actors have significantly altered each profession's capacity to exercise jurisdiction over the provision of primary birthing services. While both professions retain legal jurisdiction over these publicly-funded services, ie. both continue to be recognised as having the necessary expertise, their opportunity to compete for clients/a niche within the market has changed.

The argument is not that state actors set out to extend midwives' jurisdiction over childbirth vis a vis general practitioners through this change in maternity funding policy. Rather, this opportunity arose as a consequence of the strategies adopted by

state actors to resolve the problems they faced with regard to the funding and provision of primary maternity services. This argument is consistent with that outlined in chapter three with regard to the granting of midwifery autonomy. In both cases, the 'success' that midwives had in advancing their professional interests was due to the fact that their claims to expertise were more in keeping with the broader social and economic objectives of state actors than were those of the medical profession. Supporting autonomous midwifery enabled the state to introduce competition into the maternity sector and, having established an alternative provider, to contain costs by moving to a fixed-fee funding system.

The state's on-going concern with fostering competition between providers, in order to produce the most cost-effective and consumer-oriented services, meant that it also had an interest in giving CHEs/hospitals access to primary maternity funding. By enabling both public and private hospitals to negotiate contracts to provide primary maternity services, state actors introduced a significant new competitor into the primary maternity market. As competing providers, CHEs had the advantage of being able to (re)organise their medical and midwifery services in such a way as to offer arguably the best of both professional worlds (see chapter seven). While this provided new opportunities for midwives employed by CHEs to extend their scope of practice, it also made it harder for independent (self-employed) practitioners to compete for clients and, in some instances, access facilities.

Part two of the thesis has examined how midwifery autonomy has been negotiated at the level of policy and organisational structure. Chapters three, four and five have focussed on changing relations between the various professional organisations in the maternity field and groups of state actors following the Nurses Amendment Act 1990. In part three the focus shifts to how midwifery autonomy has been negotiated at the level of everyday practice. The following three chapters examine various forms of

maternity practice, involving both competitive and collaborative relations between midwives and doctors, that have developed as a consequence of midwifery autonomy and the creation of a quasi-market in health/maternity services.

These chapters highlight the importance of investigating jurisdictional manoeuvrings of professional actors/practitioners at the local level to appreciate the diversity of responses to opportunities and constraints that emerge as an outcome of decisions made at a national level. Chapter six examines different forms of 'independent' midwifery practice that have developed out of new relations between midwives, general practitioners and obstetricians and new maternity funding arrangements. This concern with the connection between institutional locations, funding arrangements and new forms of professional practice is continued in chapters seven and eight which focus on the (re)organisation of midwifery services in public and private hospitals and birthing centres.

## Part Three

### Negotiating autonomy: local practices

## Chapter Six

### Independent contractors: contesting jurisdiction at a local level

#### 6.1 Introduction

The challenge facing midwives who left CHE/hospital employment in the early 1990s to set themselves up in 'independent' practice was how to enter a market for normal birthing services that was dominated by general practitioners. While general practitioners did not provide a complete maternity package, in that they relied on labour and postnatal care being provided by hospital-based midwives, they were well established as the gatekeepers to maternity services. For midwives who were keen to build up their own client base, or their confidence as independent practitioners, one strategy was to provide shared care with doctors. With a fee-for-service payment system, which reimbursed both practitioners for the services provided, it was easy to become involved in this collaborative form of maternity care.

Despite its initial appeal for some practitioners and consumers, shared care did not prove to be a stable organisational form. Different approaches to the provision of maternity care, coupled with a climate of interprofessional hostility, meant that the potential for conflict or poor communication between practitioners was high. Publicity about cases where something went wrong in the pregnancy/birth invariably involved shared care between a general practitioner and an independent midwife.<sup>1</sup> As midwifery

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<sup>1</sup> For example, the Wellington newspaper *The Evening Post* (14.12.94) published the case of a woman whose birth injuries were so severe that she ended up being hospitalised twice in



became a more established maternity care option, with hospital- and self-employed midwives offering continuity of care, general practitioners found it harder to compete. While some withdrew from maternity care completely, others elected to only provide antenatal services.

The introduction in mid-1996 of a fixed-fee funding system, organised around a lead maternity care provider (LMC), contributed to a further exodus of general practitioners from the maternity field. Claims that the modular payment system did not provide adequate funding for shared care were voiced by general practitioner representatives (as discussed in chapter five). With the withdrawal of general practitioners from primary maternity care there was more opportunity for midwifery to consolidate its autonomous status. Paradoxically, this involved midwifery positioning itself (and being positioned by others) as complementary to obstetrics. Midwives and specialists were constituted as specialists in 'normal' and 'abnormal' maternity care respectively with complementary rather than overlapping jurisdictions.

This chapter examines differences between various forms of practice that developed within the category of 'independent' midwifery and how these differences evolved over time.<sup>2</sup> It shows that while these forms of practice were shaped by policy changes negotiated at the national/political level, they were also influenced by particular configurations of relations between medical and midwifery practitioners and the groups with which they were closely associated at the local level. Policy changes including the introduction of midwifery autonomy, the restructuring of health services and the reorganisation of maternity funding both enabled and constrained the activities of

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the ensuing months. She described a lack of communication between the practitioners and a reluctance on the part of the midwife to involve the doctor at the birth.

<sup>2</sup> As the focus of this chapter is on the emergence of new organisational forms for providing 'independent' midwifery care, there is no discussion of domiciliary or home birth midwifery.

organisations and groups of practitioners at the local level. As policy changes prompt diverse responses, their consequences have to be investigated rather than assumed.

This approach assumes that the market activity engaged in by midwives, doctors and clients cannot be explained either by individual motives or structural conditions. Drawing on ideas associated with 'new economic sociology' (Granovetter, 1985, 1990; Swedberg and Granovetter, 1992; Swedberg, 1997), it regards economic action as embedded in ongoing networks of personal relationships rather than being carried out by atomised actors.<sup>3</sup> This emphasis on the actual, concrete interactions of individuals and groups helps avoid not only the conceptual trap of atomised actors, but also theories that point to technology, the structure of ownership, or culture as the exclusive explanation of economic events (Swedberg and Granovetter, 1992: 9). Agency in the competitive maternity market was not related to individual decision-making but the 'embeddedness' of midwives', doctors' and clients' actions in social networks and relationships.<sup>4</sup>

The first section of this chapter draws on material from interviews with independent midwives, general practitioners and obstetricians in Christchurch between September 1992 and March 1995 to examine the development of different forms of 'independent' midwifery practice.<sup>5</sup> These various forms of practice, which straddled a variety of sites and involved different combinations of practitioners, developed out of particular sets of relations between practitioners in a context of fee-for-service maternity funding. Of particular interest was the rise and fall of shared care - which involved self-employed midwives and doctors providing either full or partial care. The latter part of the chapter

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<sup>3</sup> New economic sociology is influenced by network theory, cultural sociology and organisation theory. Other key writers include White (1981), DiMaggio (1994), Powell and DiMaggio (1991), Fligstein (1996).

<sup>4</sup> This emphasis on the relational construction of economic/market activity is consistent with the relational approach to midwifery and professionalism outlined in chapter one.

<sup>5</sup> Details on selection of practitioners and the interview process are included in the methodological appendix.

examines the consequences for 'independent' midwifery of the introduction of a lead maternity care provider (LMC) and fixed-fee maternity funding in July 1996.

## 6.2 Doing 'domino' midwifery

Despite claims that midwifery autonomy would lead to a significant increase in the number of home births, it was the 'domino' (*domiciliary midwives in and out of hospital*) maternity option that initially attracted the greatest interest from both self-employed midwives and pregnant women. By 1994, approximately 450 midwives, or 23 percent of the midwifery workforce, identified themselves as independent or self-employed (Guilliland, 1998: 44).<sup>6</sup> While a small number of these midwives chose to provide only domiciliary or home birth services, the majority opted for domino care. This form of midwifery practice, which takes its name from its English counterpart, involves midwives providing antenatal and postnatal care in the client's home and assisting with her birth in hospital. The key feature of the service is the provision of continuity of care to a client by the same midwife - or small team of midwives - before, during and after her hospital birth.

One of the first domino practices set up in Aotearoa/New Zealand following the Nurses Amendment Act was the Wellington Midwifery Service.<sup>7</sup> This practice, which was formed in August 1990, offered clients home or hospital births (Middleton, 1993). Women who chose to birth in hospital were discharged within eight hours of delivery. An evaluation of the service noted that it largely met its aims of early discharge after

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<sup>6</sup> This figure is derived from the NZCOM Membership Lists (1990-1997) where midwives identify themselves as self employed for indemnity purposes. As the fee structure is considerably higher for a self-employed midwife (\$630) than an employed midwife (\$315), it is unlikely that midwives would elect the former status unnecessarily. Some self-employed midwives could, however, still work part-time in hospital employment.

<sup>7</sup> This practice, like a similar one set up in Northland in 1989 (mentioned in chapter three), began as an area health board initiative prior to the introduction of midwifery autonomy. It was discussed in the previous chapter in relation to the primary health care projects funded by the HRD in 1991. The domino midwives undertook to develop a global fee per pregnancy for the delivery of a community based maternity service.

childbirth and the early establishment of breastfeeding (Scotney, 1992). This report, which was prepared for the Wellington Area Health Board, also noted that women who used the service were generally satisfied with their choice (with some women being extremely satisfied).

Before the establishment of the RHAs in 1993, domino midwives had contracts with the area health boards to provide normal or low-risk maternity services. These contracts, which were similar to those for general practitioners and obstetricians, gave midwives access to hospital beds and facilities. It was after the introduction of the health 'reforms' and the funder/provider split that hospital facilities became the 'property' of CHEs and access agreements for independent midwives became a contentious issue. Of particular concern to the CHEs was the possibility of being liable for untoward outcomes of care provided by independent practitioners on their premises.<sup>8</sup> Some CHEs also endeavoured to make it difficult for midwives who were employed part-time in the hospital to begin taking on some private clients.

Domino midwifery typically involved midwives within a group practice working in pairs. Each midwife got to know her partner's clients so that she could provide backup support for days off, holidays, sickness and when a number of births coincided. Under the fee-for-service funding arrangement, midwives within a practice were able to share aspects of a client's care and be reimbursed separately for the services that they provided.<sup>9</sup> To establish contacts and build up client numbers, domino midwives advertised their services through general practitioners' surgeries, kindergartens and

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<sup>8</sup> The 23 CHEs collectively commissioned a legal firm to investigate their potential liability and to define a model access agreement which would enable them to control entry to, and practice within, their facilities. This agreement was seen as problematic by independent midwives and maternity consumer representatives who were already concerned about restraints being put on midwives' practise and women's choice by CHE policies and protocols for bookings, consultation and referrals (Guilliland, Interview: 19.7.94).

<sup>9</sup> Payment for services came from the maternity benefit via the local Department of Health offices. Discussion of details on the fees paid for particular aspects of primary maternity care was contained in chapter five.

play groups, parents centres and maraes. Some of their first clients were self-referrals, while others came from general practitioners who did not provide obstetric services and were keen that their patients did not transfer to another general practitioner who did.

As the client base grew, so did the first hand knowledge/experience of what domino midwifery had to offer. The midwives soon found they were attracting family, friends or colleagues of previous clients. In some cases, this word-of-mouth promotion enabled them to tap into networks of potential clients within particular work sites as two domino midwives, interviewed during their first year of practice, explained:

I am having a lot of bookings from Westpac at the moment. I have one woman who started off with a GP. She and her husband questioned me really heavily the first night I went to see them - especially the husband who was a fireman - he really had a go at me. But I stuck to my guns and it has worked out really well. I now have another three bookings from Westpac (Domino midwife (1): 16.9.92).

Yes - it's when others see how wonderful the service is. I have had the same thing with the air traffic controllers. I have had two women whose partners were air traffic controllers and have just booked a third woman (Domino midwife (2): 16.9.92).

Domino practice was organised around providing clients with 24-hour access to midwifery care. Antenatal visits (usually once a month to 28 weeks, fortnightly to 36 weeks and then weekly to fullterm) often took up to an hour to allow time for developing a rapport between the midwife, the pregnant woman and her partner/family. When labour started, the midwife attended her client at home for as long as she requested. By not transferring to hospital until labour was quite advanced, there was a reduced need for pain relief. The midwife and/or her partner provided support throughout labour and delivery. Women were able to transfer home, or to another facility for postnatal care, within two hours of giving birth if there were no

complications. The midwife was responsible for providing postnatal care for six weeks after the birth.

After years of doing shiftwork in hospitals, domino midwives had the professional freedom to determine their own caseloads and working hours. Wearing a pager became a fact of life as they sought to provide clients with access to on-call maternity care. This new form of practice involved midwives making decisions about a raft of practice issues that they had not previously had to consider such as what caseload was realistic, how to manage work and family life, what sort of back-up they would need and how accessible they intended to be to clients.<sup>10</sup> A fundamental decision within any practice was how to organise the work in order to provide continuity of care but also ensure some regular time off. The domino midwives interviewed for this project emphasised the importance of working in pairs, both for their clients and for themselves.

Apart from the fact that it has to work better for women to know that they will have a midwife whom they've met, it also means we can support each other. In the past home birth midwives who have worked on their own have become burnt out. They never had weekends off or any free time - they were constantly on call. Even now we only have two days off in fourteen days (Domino midwife (2): 16.9.92).

These midwives, like most of their colleagues in the first independent midwifery practices, were involved in providing domino care either on a midwife-only basis or in a shared arrangement with a general practitioner or obstetrician. Providing shared care with general practitioners usually involved both the doctor and the domino midwife providing antenatal care. The general practitioner may or may not have provided

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<sup>10</sup> Concern was expressed by midwifery leaders that many of the hospital midwives who went into independent practice did so without thinking through their frameworks of practice. The NZCOM president, Sally Pairman, told me (Interview: 25.11.93) that a lot of midwives were at risk of burnout because they had not established boundaries in terms of their professional responsibilities. In some cases, midwives had made themselves too accessible which led to clients becoming dependent on them rather than empowered by them.

delivery care, depending on whether he/she held an obstetric diploma and a contract with the area health board. General practitioners who did not do intrapartum (labour) care often only shared the antenatal care up to 28 weeks. Postnatal care was largely the midwife's responsibility, although some doctors did make the occasional home visit. In many cases, domino midwives opted to provide shared care with general practitioners as a way of building up their caseloads.

Because the two of us have just started we had a lot more shared care at the beginning. When we started off we had to get extra bookings for (partner) from June and, of course, a lot of those women had already started their care. So most of our early clients were shared care. But now we have an increasing number of midwife-only care - although it wouldn't be 50:50 yet (Domino midwife (2): 16.9.92).

Shared care was a potentially difficult arrangement for both self-employed midwives and medical practitioners. As independent practitioners with overlapping professional jurisdictions, some midwives and general practitioners had difficulties negotiating new relations with each other and their mutual clients. Differences in training and approach to childbirth, both within and between the professional groups, meant that shared care arrangements were highly variable. According to the domino midwives interviewed for this project, some general practitioners wanted to be actively involved in the management of labour while others were happy not to be involved unless their medical skills were needed. Not surprisingly, the midwives found it easiest working with general practitioners who were experienced in home birthing.

I had a really good experience with a GP who has been involved with home births. He came into the room and we hadn't established antenatally who was responsible for what. The doctors with the least experience are very cut and dried about who is to do what. One GP I've shared care with is adamant that she takes responsibility in labour and she will do the birth. She is not very experienced - because of that she has to feel it's her responsibility. I keep it amicable but I don't like it inside. But this GP, who had done home births, walked in and said you carry on with the birth and I'll keep an eye on the baby if there's any need to. That was really great (Domino midwife (2): 16.9.92).

I've had quite good experiences except for a couple and those two (GPs) I wouldn't bother working with again. One GP I was working with - we were supposed to be doing shared care - he was okay until we got to about 34 weeks and then he wanted to see her (the client) as though it was just him providing the care. I was left trying to squeeze in visits - it was just hopeless. I decided that in the future I won't work with him again. If a woman under his care comes to me asking for shared care I'll just say that he either doesn't want to do it or doesn't understand it (Domino midwife (1): 16.9.92).

Under the fee-for-service funding arrangement neither practitioner in a shared care arrangement was designated as the principal care provider. This was an advantage for self-employed midwives who were looking to shed the subordinate 'doctors' handmaiden' role and establish themselves as autonomous practitioners. However, it also meant that the potential for interprofessional rivalry and poor communication in some cases was high (this issue is discussed from a medical perspective later on in the chapter). As many domino/independent midwives built up their client base, they were either not prepared to share care or were increasingly selective about who they would share care with.<sup>11</sup> This shift was supported by evidence produced by NZCOM standards review committees to show that the outcomes for women with normal pregnancies/births were better with midwife-only care (Pot, 1996).

Domino midwives sought to offer continuity of care within a model of midwifery practice in which the client was central in the decision-making process.<sup>12</sup> While the

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<sup>11</sup> Standards review statistics for independent midwives practising in Auckland between 1991 and 1994 showed a significant increase in the number of midwife-only births compared to shared care births (Pot, 1996). Of the 634 births attended by independent midwives in 1991, 37 were midwife-only and 597 were shared care. Of the 1590 births in 1992, 405 were midwife-only and 1185 were shared care. Of the 3205 births in 1993, 1310 were midwife-only and 1860 were shared care. Of the 4072 births in 1994, 1910 were midwife-only and 2162 were shared care.

<sup>12</sup> This model of practice is similar to that adopted by domiciliary or home birth midwives except, of course, for the place of birth. Some domiciliary midwives and home birth consumers in the NZCOM expressed concern about how medicalised some independent midwives' approach to care was. According to Donley (Interview: 17.1.95) these midwives were not 'independent' because their access agreements obliged them to adhere to hospital protocols and this brought them under the control of obstetricians.



domino midwives I interviewed did not talk about 'partnership' as such, they did make reference to midwives and clients forming a "special relationship". They positioned themselves as facilitators of a different pregnancy and birthing experience than that commonly associated with medical practice. Central to this experience was women/clients having control over their birthing process even if it did not go according to the birth plan. One midwife's description of a client's birth that required various forms of medical intervention highlighted the importance she placed on women being consulted throughout the process regardless of whether it was a 'normal' birth or not.

It seems that whatever experience they (clients) have in labour, whatever the outcome, by the time you finish their postnatal care it's a special relationship. And they are so happy with it even if it hasn't gone the way they expected (Domino midwife (1): 16.9.92).

At least they (clients) know they have been part of the decision-making - that every possible thing was done to enable them to have a normal birth. A lot of women - if they recount their birth experience - say that the doctors did this, the doctors did that, they didn't ask me. They felt totally powerless and out of control. And yet our women ... one woman of mine had a really long labour, was transferred into a base hospital, had an epidural, got to full dilation, tried everything and even thought about a forceps delivery. Finally, she had a caesar (caesarean section) but she was okay. She had been consulted every step of the way and had been totally supported (Domino midwife (2): 16.9.92).

The next section of the chapter focuses on 'independent' midwives who chose to offer shared care, either with general practitioners or obstetricians, as a particular form of independent midwifery practice. Unlike their domino colleagues who often shared care either as a means of accessing clients or at a client's request, they opted to practice in collaboration with medical practitioners. These midwives were located in networks of relations with general practitioners and obstetricians with whom they had worked in a subordinate capacity in hospitals prior to the Nurses Amendment Act. These relations could be developed to mutual advantage in a context in which maternity services were

funded on a fee-for-service basis and there was a demand from consumers for collaborative care. This section includes interview material from general practitioners who provided obstetric care in a variety of arrangements with self-employed midwives.

### 6.3 Sharing care with general practitioners

The reason why I shared care with a GP was that I really believed in it. I really believed that it was a good option for care at the beginning. I only ever shared care with one particular GP. I believed in how he practised - that he cared about the women. I felt that our practices complemented each other and that the women liked it - and most of them did - like we had some of them back four times. I felt that they got a really good deal (Shared care midwife: 2.12.98).

I initiated the shared care arrangement for lots of reasons - one of them is politics. I hate politics and I am involved in it up to my eyeballs. I reckoned that politics was going to change the environment of GP obstetrics quite a lot and if I didn't get in and start making changes then I might miss out. I don't go around the community canvassing for patients - I don't advertise - I don't go out there and say that I do obstetrics and why don't you come to me. I rely on the fact that I have been here a while and they know that I do it. But my midwife colleagues have other ways of marketing themselves that I don't have control over. If I sat back and did nothing then potentially I would lose obstetric patients and I enjoy the obstetric side of things so I don't want to do that. So I thought how am I going to overcome that - maybe offering a midwifery service is the way to do it, but equally I don't want to give it up (General practitioner (male): 15.3.95).

Shared care as a maternity option offered by self-employed midwives and general practitioners developed in response to the introduction of competition among providers in the primary maternity market.<sup>13</sup> This form of care usually involved both practitioners

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<sup>13</sup> This discussion focuses on general practitioners who chose to provide some form of shared care with independent midwives. There were other general practitioners who refused to collaborate with self-employed midwives and put pressure on pregnant women to choose either medical or midwifery care. According to a spokesperson for the Auckland Maternity Consumer Council, there were women in rural areas who were being coerced into using medical maternity services. She cited a case where a woman who chose midwife-only care

providing antenatal care - often doing alternate appointments either in the doctor's surgery or in the client's home.<sup>14</sup> Any maternity problems outside surgery hours were handled by the midwife. She was the practitioner who accompanied the client into hospital (where she was booked in the doctor's name) and provided labour care. The general practitioner was usually called just prior to the birth and he/she usually left soon afterwards. The midwife did the cleaning up and completed the paperwork related to the birth and the client's admission to a postnatal ward or transfer to another facility. Postnatal visiting in the home was the midwife's responsibility.

While this form of practice was facilitated by the fee-for-service funding of maternity services, as discussed in chapter five, it also relied on the existence of previously close working relations between some general practitioners and hospital midwives. These practitioners often had a lengthy association through working together in hospital labour wards and knew and respected each other's practice. The general practitioners were familiar with the skills/expertise and approach to childbirth of particular labour ward midwives. These midwives, in turn, had a good idea of which general practitioners and/or obstetricians they could work with in independent practice. The fact that there was this compatibility between some practitioners attested to there being similarities as well as differences within and between the professional groups.

In the climate of interprofessional competition and hostility following the introduction of midwifery autonomy, there were advantages for both general practitioners and newly self-employed midwives in teaming up to provide shared care. For both midwives and doctors, it offered an alternative to the difficulties involved in having to continually

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was told by doctors in the only local practice that they would not provide medical care for her or her family if she continued with independent midwifery care (Strid, 1994: 15).

<sup>14</sup> Some arrangements involving general practitioners and self-employed midwives were less 'shared' with the midwives having minimal, if any, antenatal input and providing mostly labour support in hospital. This arrangement was not supported by the NZCOM primarily because the midwives involved were not providing clients with continuity of care. See Pairman (1998: 20-21).

negotiate with independent and hospital-based practitioners with whom they either had no prior relationship on which to base trust/confidence or they possibly did not share a similar approach to providing maternity care. This was particularly significant for general practitioners who found themselves not only competing for clients with highly experienced and skilled midwives in the community, but also having to work with less experienced and constantly changing midwifery staff in the CHE/hospital labour wards. As one Christchurch general practitioner explained:

I found I was no longer dealing with the people that I was familiar with. I was dealing with a whole lot of new staff because the staff suddenly changed and there were a lot of new midwives coming through all the time. I didn't really like it that much. Instead of getting only one or two people at Women's a month who were new - I could cope with that - I was now getting calls from maybe six or seven a month that were new to me. When they said that the situation was such-and-such - maybe it was - but maybe it was just their interpretation. So I was always having to check.

Practising in conjunction with one midwife has worked out brilliantly. I know when (the midwife) rings me up and says that so-and-so is 7cm and feels a bit pushy - I know exactly what the situation is. I know when she says the woman is pushy that I really do have to get out of bed because if I don't I will miss the birth. Whereas if someone else rang me up and said that I might roll over and go to sleep for another five minutes and take a bit of time to think about getting out of bed. So it has been good - I know what I am doing (General Practitioner (male): 15.3.95).

By offering maternity care in conjunction with a particular self-employed midwife, general practitioners reduced the risk of losing their pregnant patients either to another doctor who offered shared care or to an independent midwife. They also, of course, stood to attract clients who were looking for a general practitioner who offered shared care. The arrangement therefore enabled general practitioners who had a professional interest in continuing with obstetrics, and who were concerned at the competition from independent midwifery, to organise their practice around a collaborative form of maternity care. For newly self-employed midwives involvement in this collaborative

maternity practice offered professional support from a medical colleague and access to his/her clients and facilities. While this option was mutually beneficial for some providers under the fee for service funding regime, the situation changed with the introduction of a lead maternity care (LMC) role in mid 1996 (see discussion later in this chapter).

General practitioners chose to do obstetrics for a variety of reasons. For some younger doctors who were getting established, offering maternity care (or at least antenatal care) was a means of attracting younger people and families into their practice. Given that the majority of their colleagues did not offer full obstetric care, there was also the possibility of attracting their pregnant patients.<sup>15</sup> For some general practitioners who did a significant number of deliveries a year (50 plus), obstetrics contributed substantially to their income. For example, a general practitioner who was delivering 50-60 women a year in the early 1990s considered the \$10,000 in maternity benefit payments that she received a significant part of her income (Interview: 10.9.92).<sup>16</sup> The financial rewards for doing obstetrics did, however, have to be weighed up against the potential disruption to surgery hours and/or sleep by the need to attend women in labour.

Some general practitioners who did obstetrics claimed that it was an important component of general practice medicine. As the providers of a range of primary family health services, they regarded themselves as well positioned to offer maternity services. In some cases, they had a relationship with the patient that preceded her being pregnant

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<sup>15</sup> The NZMA estimated that approximately 20-25 percent of the general practitioners practising in 1994 provided intrapartum or full maternity services (Guilliland, 1998: 66). Only a small proportion of women general practitioners offered full maternity care because of the disruption it could cause to family life.

<sup>16</sup> This female general practitioner attracted clients from all over the city who wanted a woman doctor involved in their maternity care. While gender provided this medical practitioner with a particular niche in the market, she did not use it as a discursive resource in framing her approach to maternity practice.

and they would, they claimed, be the practitioner most likely to provide her on-going health care plus wellbaby/child care.

Our role has always been - because we look after families - a lot of these girls who are having babies now - we have managed them since they were kids. So we are seeing them right through from the beginning. We see them when they first get pregnant - often we have put them on some sort of contraception first. Then they get pregnant - we follow them right through - and most of them will continue to be under our care with us as the lead professional because we have seen so much more of them. We know them much better than anybody else - and likewise we are going to be following them afterwards (General Practitioner (male): 17.2.95).

I believe that pregnancy is an important but small part of someone's overall health picture. There has to be input at the beginning before all that to say that you are healthy and that your rubella status - all those minor issues are appropriate - in the same way that you have to have someone you can pass on the responsibility for wellchild care and immunisation and so on. Within the system as it stands at the moment I believe that general practice/family medicine still holds that overall 'container' to do that provided GPs are adequately trained to do wellwoman, antenatal type care and wellchild, immunisation, developmental type care (General Practitioner (male): 15.3.95).

In making such claims, general practitioners locate pregnancy and birth as part of a woman's broader health picture - a picture that begins before pregnancy and extends beyond labour. In doing so, they locate maternity care within a general practitioner's jurisdiction over a wide range of primary health services. Ironically, while services such as wellwoman and wellchild care and immunisations are available through general practices, they are often the responsibility of practice nurses (Mortlock, 1996). However, in a context in which there was increasing interest in, and demand for, holistic and preventive primary health care, it was useful for general practitioners to position themselves as practitioners with the expertise to not only perform the medical tasks of diagnosing and treating illness, but also to monitor 'wellness'.

Some GPs don't - because they don't do obstetrics - but most do provide continuity of care because during a pregnancy lots of other things happen - you might get the 'flu, a sore throat, diabetes, you might have a family crisis... So we have to put the fact that she is pregnant into the equation of how to fix them up and sort out what is going on. So health and welfare and care goes well beyond just worrying about the uterus (General Practitioner (male): 17.2.95).

This emphasis on maternity as part of 'wellwoman', holistic medical/maternity care is associated with several different understandings or explanations of birth as a 'normal' process. While these claims may vary in form and content, they share a concern with constituting medical expertise as necessary for the performance of certain tasks involved in the provision of 'safe' maternity care. Some of these claims are influenced by a mechanistic, 'body as machine in need of maintenance' type approach where the doctor is positioned as the expert in monitoring and intervening to keep things in good working order. Other claims are more consistent with an understanding of birth as a normal/natural process but with the proviso that there are potential risks that may require medical intervention.

There is nothing better than having normal people to look after ... the pregnant girls are in the main the only people we see who are not ill and who are in a condition that makes them happy to come and see us. They are well and all we are doing is watching the dials and gauges and making sure that something is not starting to overheat somewhere and smoke is not coming out of something else (General Practitioner (male): 17.2.95).

Having babies is a particularly easy process that can go disastrously wrong. You can't get away from it mothers and babies die giving birth. If you are going to be in the game you have to be able to provide something particularly simple, but you have to be able to whip out the gizmo and knowledge if something happens (General Practitioner (male): 10.11.94).

Claims such as these were strategic in terms of distinguishing general practitioner obstetric services from the services offered by midwives. The statements show how

some general practitioners were positioning themselves as generalist primary health/medical practitioners whose main concern with regard to maternity care was monitoring and prevention, but who could also draw on medical knowledge/skills and technologies ("the gizmo") to manage the unexpected. It was this capacity to draw on medical expertise to deal with problems that might arise in a patient's pregnancy/labour, or general state of health, that they claimed distinguished their services from those of midwives. In making this distinction, they sought to attract patients/clients with uncomplicated or low risk (ie. normal) pregnancies who wanted medical input into their maternity care.

A difficulty facing general practitioner obstetrics, in its attempts to secure a niche in the competitive maternity market, was the fact that it did not constitute a complete maternity service. As practitioners who offered maternity care on an episodic basis, general practitioners relied on supplementary care being provided, particularly during the labour and birth and postnatally, by midwives. Before the Nurses Amendment Act, accessing this care involved simply sending a patient into a hospital labour or postnatal ward. However, with the introduction of midwifery autonomy, general practitioners faced the difficulty of trying to access or organise care provided by either self-employed or CHE-based practitioners with whom they were potentially competing for clients. Even when this shared/complementary care could be arranged, there was always the potential for a clash of philosophies and/or practices.

All along the way the potential is there because everytime something happens and a decision needs to be made then the likelihood of conflict is quite high - especially as midwives and doctors tend to have very firmly held beliefs. For instance, if I have a woman who has really cracked nipples and her milk has come in and she is struggling to breastfeed I might say why don't we try a nipple shield. And the midwife will hold her hands up in horror and say I never use nipple shields - they are a total disaster. That's really awkward and the patient gets left in the middle - not knowing what to do and who to listen to. People doing obstetrics - usually they



believe what they believe quite firmly - so they tend not to be into compromises as a solution (General Practitioner (female): 15.11.94).

As noted earlier, difficulties in the shared care arrangements often arose from the fact that practitioners who had different training and skills, and who were embedded in different forms of practice and professional/client relations, had overlapping areas of expertise. Without legally defined jurisdictional boundaries to demarcate areas of expertise and responsibility, it was inevitable that there would be ongoing contestation between some practitioners over the distinctiveness and desirability of their approach to the provision of maternity care. This contestation over how, and by whom, aspects of pregnancy and birthing care should be provided became more intense as changes to the system of funding primary maternity services made it more difficult, and less lucrative, to provide shared or collaborative care (discussed later in chapter).

#### **6.4 Sharing care with obstetricians**

Among the midwives who took the opportunity to practice in a self-employed capacity were those who chose to provide shared care with obstetricians. After years of working in base hospital antenatal and labour wards, many of these midwives were highly skilled in dealing with 'abnormal' pregnancies and births. For some of them it was important to maintain these skills and put them to use in a form of independent maternity practice where they were most sought after by both clients and other practitioners. By taking advantage of the opportunities arising to provide shared care on a formal/organised basis with particular obstetricians, they could achieve both these objectives.

I chose to work with an obstetrician because I feel that the college (NZCOM) talks about the 80 percent of women who have the ability to have a normal delivery but they never discuss that other 20 percent whom I feel are really important. Obstetricians do not go out onto the street and round up women - women choose to

go to obstetricians. Usually they go because they have had a bad experience with their first pregnancy or they have to go because of some complications and I think these women are as entitled to midwifery care as the so-called normal women. In fact a lot of them need the midwife much much more (Obstetric midwife (1): 10.5.94).

I see us very much as the levelling influence within what can be a complicated environment. That we endeavour to keep things as normal and steady as possible. Because obstetricians are often male and always busy - there are a huge number of concerns that women cannot express easily to them. That's where I see a huge role for us - because we have the time, we're women and we are often the normal aspect of their complicated pregnancy and labour (Obstetric midwife (2): 10.5.94).

Arguments like these were advanced by midwives in defence of their decision to practice in conjunction with obstetricians. These claims centred on the appropriateness of midwifery care for women who, either by choice or by necessity, had an obstetrician as the principal practitioner. They drew attention to the differences that exist among birthing women and midwives. Differences related to factors such as age, social background and health status meant that not all pregnant women were suitable clients for midwife-only care and, even among those that were, not all would necessarily choose that form of maternity service. Similarly, not all midwives chose to provide independent care according to the model promoted by the college. For midwives who were highly experienced and skilled in assisting obstetricians with complicated/abnormal cases, a model of care in which the focus was on normal childbirth had professional limitations.

If you are dealing with the abnormal you have to keep doing it to keep good at it. The ones (midwives) that have gone out into the community three or four years ago - and haven't managed things like epidurals - often don't do it as well as they would have done when they were still at the base hospital (Obstetric midwife (1): 10.5.94).

I think that when there are people like us who have worked in the area for a long time and are very skilled at the abnormal - you don't want to go into very normal

obstetrics when you have spent the time gaining the skills to look after other women (Obstetric midwife (2): 10.5.94).

This form of 'independent' midwifery practice was problematic for the NZCOM in its determination to establish midwifery as a profession specialising in normal childbirth. The model of practice promoted by the college involved practitioners providing continuity of care throughout the normal or low-risk pregnancy/birthing experience. Like some of their colleagues who worked with general practitioners, these midwives may have only seen a client once or twice during her pregnancy as the focus of care was labour support. They were also not necessarily the midwife within the obstetric practice that provided the postnatal care. By working within an obstetrician's practice, these midwives could be seen as supporting a form of maternity care that was potentially highly interventionist. From the college's point of view, it was more appropriate for midwives to practice independently of obstetricians, as specialists in their own right, and consult as and when necessary.

In their defence, 'obstetric' midwives could point to birth outcomes where their involvement arguably contributed to the woman not requiring forceps or a caesarean section. Their accounts of these outcomes are interesting in that they use the term 'normal' for births where there was obstetric intervention, in the form of an induction, epidural (anaesthesia) and electronic foetal heart monitoring, but the baby was delivered vaginally. This understanding of a birth as 'normal' if it did not require a caesarean section, ie. secondary/surgical care, is more consistent with a medical/obstetric model of practice than a midwifery model.<sup>17</sup>

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<sup>17</sup> Treichler (1990: 129) notes the multiple meanings of the term 'natural' in childbirth discourses. She says that it can mean birth without the panoply of hospital procedures, birth with Lamaze and/or without anaesthetic, birth outside the hospital, vaginal delivery as opposed to caesarean section or the outcome of "natural" rather than in vitro (test tube) fertilisation.

One of the things that I have been pushing to the college girls is that because we look after a high number of abnormal pregnancies/labours - and because we have been doing it for so long and I think we are all very skilled at it - that a much higher ratio of the consultant's patients are getting vaginal deliveries. We know how to manage syntocinon and epidurals and we know how to read cardiotocograph readings. Whereas - and I'm not trying to put down my colleagues - but there are a lot of very junior midwives in the hospital who panic and ring the consultant who gets fed up and opts out and does a caesar. I know for a fact that all of us would have produced far more vaginal deliveries because of our expertise (Obstetric midwife (3): 10.5.94).<sup>18</sup>

... in the 11 months that I have been working with (obstetrician) we have had seven babies that we have known to be breech - of those four have had assisted breech deliveries vaginally and three have had caesarean sections. Of eight women with trials of scar (previous caesarean sections) five have had normal deliveries and three have had caesarean sections. Women with previous forceps deliveries - I have had eight of those - this time six have had normal deliveries and only two have had to have forceps. Both of those have needed forceps to turn the baby - it hasn't just been because they couldn't push the baby out. In all of those cases more than half have had successful outcomes (Obstetric midwife (1): 10.5.94).

The obstetric midwives interviewed for this project recognised their approach as being different from that of some other independent midwives with whom they worked in their capacity as part-time hospital/labour ward midwives. They spoke of "philosophical differences" between themselves and some of their colleagues within the NZCOM and the fact that some of these midwives were prepared to take "risks" that they were not prepared to take. Like the obstetricians interviewed, they expressed a concern with women not being adequately prepared for the possibility of problems arising in their pregnancy/labour which could require intervention. In their view, this lack of preparation stemmed from the belief held by some independent midwives that childbirth was 'normal' and consequently problems would not arise.

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<sup>18</sup> Syntocinon is an artificial hormone which is administered via an intravenous drip to stimulate contractions. Cardiotocograph or CTG readings show the foetal heart rate.

What we see in our clinic role (in the hospital) is that we get women who have got into bother at home or in peripheral hospitals and they haven't been told by their midwife that in that situation they may have to be transferred to a base hospital for an epidural and/or forceps and/or a caesar. They come to us and they are out of their tree. They don't want to be there. They have never talked about it. And they hate us - so it is a really good start (Obstetric midwife (3): 10.5.94).

There certainly is a group of midwives with a philosophy that everything is normal and their women are never prepared for what if this or that might happen. Part of that may come from the women themselves but I think it is a mutual thing. None of these women have ever thought of the possibility that they may need an epidural or a caesarean section. They have thought only that things were going to be normal and not interfered with and nothing could stop that (Obstetrician (female): 21.12.94).

Not all midwives are like it - but there is a hard core, small group who are a complete and utter law unto themselves. They believe that they can do every damn thing under the sun. They are the ones who will try and do the breech delivery having never done one in their life before - having never been shown how to do it. They will be perfectly confident that it is a natural process and they will manage it (Obstetrician (male): 2.12.94).

These statements show how obstetric and midwifery practitioners who subscribe to a more medicalised approach to maternity care utilise particular meanings of 'normal' (and 'natural') to position other practitioners as irresponsible or unsafe and themselves as 'experts' with the appropriate knowledge and skills. The comments of midwives who elect to share care with obstetricians highlight how critical the demarcation between normal and abnormal childbirth is to the division of labour between midwifery and obstetrics. While 'normal' birth is not the subject of definition in law, it is the subject of professional judgement and increasingly open to contestation.<sup>19</sup> Attempts by midwives who work with obstetricians to construct themselves as experienced and

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<sup>19</sup> Criteria for referral to obstetric and related medical specialist services were developed by the combined RHAs in consultation with health/maternity professional organisations. These guidelines, which were released in April 1997, outlined three levels of referral and action that LMCs could pursue in relation to more than 200 conditions/situations. Both the NZCOM and general practitioner associations favoured guidelines rather than protocols on the basis that decisions about referral were a matter of professional judgement.

skilled with respect to 'abnormal' births are consistent with/used to support obstetricians' claims about new and experienced midwives and potentially consolidate obstetricians as the arbiters of midwives' skills.

These perceived variations in independent midwives' level of skill in dealing with abnormal cases meant that there were practitioners with whom obstetricians were reluctant to consult over clients. From the interviews, there was no suggestion of a gender difference in how obstetricians practised vis a vis independent midwives. Both the obstetricians interviewed based their relations with midwives on how much trust they believed they could put in the midwives' professional judgements.<sup>20</sup>

There are midwives we work with very commonly who are great and whom we trust implicitly. We know they'll call us when they need to. And then there are others who refer and we think 'oh no, it's not that person's patient' because there have been times when things have become difficult and the care has been less than optimal. I would have wanted much more involvement but I haven't been called (Obstetrician (female): 21.12.94).

With regard to the most skilled and experienced independent midwives - they will function well but will bail out when they are in trouble or will recognise that something is not normal. I will see consultations for them. They will send someone and say 'what do you think of this patient - should I consider induction?'. Fine, I have no problem with that. They will say 'can I call you if I get into trouble?'. Fine, no problem. But I get bloody ticked off with somebody who arrives in labour ward with a stillbirth because they haven't asked for help (Obstetrician (male): 2.12.94).

These statements highlight the reliance that specialists had on the primary practitioner continuing to consult, or at least keep them informed, on a case in which they had been involved. Apart from concern about the well-being of the mother and baby, there were

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<sup>20</sup> The woman/female obstetrician believed that she did practise differently to her male colleagues - some of whom saw themselves as "this god-like, powerful person" - but this did not stop her having concerns about the way that some independent midwives practised. See Pringle (1998) for analysis of the role of women obstetricians.

medico-legal issues to consider. Prior to the introduction of a LMC provider, an obstetrician could be held legally responsible for the care of a patient over which he/she had consulted regardless of whether they were subsequently called by a primary practitioner when problems arose. Consequently, they had to rely on general practitioners' and midwives' professional judgements about when a client's care required specialist input. From the experience of the obstetricians interviewed, there was more resistance to their involvement from some groups of midwives than from general practitioners.

Most of the GPs we work with - we have a good relationship with. There's no GP that I would think 'oh no, so-and-so is referring this patient to me'. There have been one or two difficulties but it only takes a phone call to sort them out whereas ... I think the communication has been better with GPs ... and that often they see us as a consultant and therefore taking over in terms of our knowledge. Whereas there is a group of midwives who set up a barrier to that and there is resistance - not that I am the sort of person who likes to take over completely and not respect someone from their midwifery point of view. But I think that in terms of high risk decision making that is our training and is what we are good at hopefully (Obstetrician (female): 21.12.94).

The likelihood of obstetricians and general practitioners finding it easier to share a client's care was understandable given not only their medically-oriented approach to maternity work, but also their established patterns of consultation and referral. As generalist and specialist members of the same profession, they were embedded in networks of professional and social relations in which consultation was an established practice.<sup>21</sup> This meant that as practitioners who shared an understanding of childbirth as a potentially risky event most safely managed by those with medical expertise, they were also unlikely to be engaged in territorial disputes despite varying levels of skill

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<sup>21</sup> One of the general practitioners said (Interview: 17.2.95) that if he ever "got into trouble" he rang a specialist colleague with whom he consulted regularly. This specialist had once told him that general practitioners should practise "no sweat obstetrics" and consult for anything out of the ordinary.

amongst general practitioners. Obstetricians, overall, had a sense that general practitioners were less likely than some independent midwives to go beyond their scope of practice and thereby put them at professional risk.

Discussion of the various forms of independent and shared maternity care that developed in the primary sector in the early 1990s highlights the complex sets of relations in which self-employed midwives, general practitioners, obstetricians and clients were embedded. For midwives and general practitioners, these relations were particularly complicated as they were positioned as both competitors for clients and potential collaborators in the provision of primary maternity services. While these practitioners endeavoured to constitute their services as distinctive in order to secure a clientele, they were still effectively competing for the same niche in the market. From the interviews in this chapter it is evident that, while fee-for-service induced cooperation between some practitioners, it also made that cooperation difficult.

### **6.5 Doing 'partnership': Consumer critique**

By the mid-1990s self-employed midwives were engaged in various forms of independent practice involving new and different relations with their colleagues, medical practitioners and clients. While statistics showed that an increasing number of midwives and clients were opting for midwife-only care, a significant proportion continued to be involved in collaborative arrangements.<sup>22</sup> Where these arrangements involved an equitable sharing of care and responsibility and, most crucially, midwives were able to provide continuity of care, the NZCOM gave its qualified support. However, where the arrangements involved self-employed midwives providing only

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<sup>22</sup> Research conducted in December 1995 found that the predominant service provided by self-employed midwives throughout the country was midwife-only care (Guilliland, 1998: 113). Of the 413 self-employed midwives who participated in the survey (82 percent of the total number of self-employed midwives in Aotearoa/New Zealand at the time), 54 percent provided full midwife-only care. The second most common option was full shared care with general practitioners (27 percent).



labour and birth support or other components of care, college leaders voiced their concerns (eg. Pairman, 1994).

Of particular concern to midwifery leaders, and maternity consumer representatives involved in the NZCOM, was the disregard that some practitioners showed for the 'partnership' model of midwifery practice. This model of practice, which developed out of mutually-supportive relations between midwives and consumers involved in home birthing in the 1980s (as discussed in chapter four), was identified as the foundation of midwifery practice in the college's philosophy and code of ethics (NZCOM, 1993: 7,10) and the standards for registration used by the Nursing Council (NCNZ, 1992: 1). What this model of professional practice meant for midwifery was developed and articulated in various formats by the college's national director, Karen Guilliland and president, Sally Pairman (1994, 1995).

Central to Guilliland and Pairman's model of the midwifery partnership was "a relationship of 'sharing' between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding". This model of practice involved midwives working alongside women both as individuals giving birth (at a professional/client level) and as consumers of birthing services (at a political/organisational level).<sup>23</sup>

It is this sharing relationship which constitutes midwifery and it is one which spans the life-experience of pregnancy and childbirth. Because of the individual nature of the relationship, midwifery's practice of partnership is a personal one between the woman and the midwife... Because midwifery recognises the social context of all women, the partnership is also a political one at both a personal and organisational level (Guilliland and Pairman, 1995: 7-8).

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<sup>23</sup> The involvement of maternity consumer representatives in key areas of NZCOM activity, including the national committee and regional standards review committees, was discussed in the introductory chapter.

Guilliland and Pairman argued that there was a true or essential meaning of midwifery which could be "rediscovered" as midwives moved from being dependent practitioners within the medical model of childbirth to being independent practitioners within the midwifery (partnership) model. This 'authentic' or 'true' form of midwifery practice (a) recognised pregnancy and childbirth as normal life events, (b) was provided independently of other disciplines, (c) was provided continuously throughout the entire childbirth experience and (d) was women-centred (Guilliland and Pairman, 1995: 34). The concept 'women-centred' was used to differentiate a midwifery model of pregnancy/birthing care from a medical model. While the latter focussed on the foetus or baby with decision-making resting with medical practitioners, the midwifery model put the woman at the centre of care and supported her right to control her pregnancy and birthing experience.<sup>24</sup>

In positioning midwives and birthing women as partners who share responsibility for the pregnancy/birth, midwifery leaders drew on radical feminist understandings about the importance of women taking control over their lives and health in general, and their reproductive experiences in particular.<sup>25</sup> This discourse of 'partnership' put feminist concerns about issues of responsibility, control, empowerment and choice in health/maternity care at the centre of midwifery's definition of itself as a profession with a "moral obligation to work in partnership with women". By redefining the professional-client relationship as one of 'partnership', in which each partner contributed knowledge and experience, it also embraced feminist criticism of the

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<sup>24</sup> Feminist poststructuralist analysis has subjected the notion of 'women-centred' midwifery care to critical attention. Annandale and Clark (1996: 522; 1997) have argued that this concept is "ideologically saturated with radical feminism and tends to be used politically as a point of contrast to obstetrics". This is where it gains meaning as there is no intrinsic 'truth' or value in the term.

<sup>25</sup> The term 'radical feminism' covers a wide spectrum of thought. Ramazanoglu (1989) identifies it as the feminism most difficult to define because of its diversity. In its strongest form, there is a celebration of women's bodies and the capacity to nurture and create (Gatens, 1992) and motherhood is celebrated (Weedon, 1987).

hierarchical power relations involved in the doctor-patient relationship and the consequent devaluing of women's knowledge.

Midwifery's use of a 'partnership' model of practice presents a reworking of more orthodox ways of doing professionalism (as discussed in relation to 'new' professionalism in chapter two). By constructing a professional identity based on 'partnership' with clients/consumers, midwifery leaders were able to make particular claims over birthing 'work' which differed from those of rival health professionals such as doctors and nurses. These claims, which related to midwives' knowledge/skills and relations with women in childbirth and maternity politics, were made in an effort to secure professional control or jurisdiction over 'normal' maternity care vis a vis doctors. Claims about 'partnership' were therefore used to strengthen midwifery's position in the competitive medical/health division of labour.

The challenge for midwifery was putting this discourse of professionalism into practice. Institutionalising the 'partnership' model of practice involved reworking understandings and relations associated with the construction of professional 'expertise'. Most importantly, it involved constituting midwifery practice as autonomous in relation to competing health professions, but not autonomous with respect to clients/consumers. To produce practitioners who shared this understanding of midwifery as a form of feminist professional practice in which knowledge and power were shared with clients/consumer representatives, it was essential that the profession gained control over its training system (as discussed in chapter four). For some practitioners who trained and registered under the former nurse/midwife system, however, this 'partnership' model could seem an inappropriate way to practice.

For midwives who chose to provide shared care with doctors, or continued to provide midwifery care on a rostered basis in hospitals, the definition of midwifery which was

legitimised within the professional discourse of the college was sometimes problematic. Their location within work sites such as medical practices and hospital labour wards, and their embeddedness in networks of relations with general practitioners, nurses, hospital managers and clients, sometimes contributed to different understandings of how midwifery care should be provided than the model promoted by the college. For some midwives, ideas about 'partnership' were enabling in that they provided the philosophical basis for independent practice. For other midwives, 'partnership' as defined by the college involved a radical departure from their training, their sense of appropriate professional boundaries and their preferred form of practice.

Some practitioner concerns about the partnership model of practice were expressed in several letters to the editor in the *New Zealand College of Midwives' Journal* (1995). Of particular concern was the emphasis that Guilliland and Pairman placed on 'continuity of care'. These midwives argued that the relationship formed between a hospital midwife and a woman during labour and birth was often a 'partnership' which, while it did not involve continuity of care, did involve individual negotiation, equality, shared responsibility and empowerment (other key principles identified by Guilliland and Pairman). One midwife wrote: "We need to remember that not all women subscribe to the belief that the birthing process must include all the elements which we may see as ideal. Neither do all midwives" (NZCOM Journal, 1995: 6).<sup>26</sup>

Excerpts from interviews in mid-1994 with several midwives, who were involved in CHE-based and independent practice, show different understandings about what 'partnership' entailed and its value as a model of professional practice. These comments

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<sup>26</sup> The first PhD in midwifery completed in Aotearoa/New Zealand challenged the assumption that continuity of care by one midwife from conception to six weeks after the birth was necessary. After researching an independent midwifery practice in Dunedin in 1991, Fleming (1995) concluded that this arrangement was "lovely for the woman - but where it didn't happen it didn't matter". She found that an arrangement where the client met two or three midwives, one of whom provided labour care, was acceptable to the women in her study.

highlight differences between groups of midwives within 'the' profession of midwifery as well as between birthing women.

The partnership idea is a romantic ideal. They say that midwifery is for women and I think that's great - but I think it is a romantic idealistic attitude to think that lay people can have equal input into professional issues. Sure they are the consumers - and the whole reason we are here - I am not knocking that in the slightest - but somewhere you have to draw a professional line (CHE and self-employed midwife (1): 10.5.94).

The dominos and the home birthers are catering for really motivated women who are articulate and know what they want. Midwives in hospital labour wards are often caring for women who don't want to be pregnant and are ill-prepared for the birth. Some are drug addicts and are totally out of control. It is really hard to say 'I am in partnership with you and we are going to work out your care plan' when she can't work out what her life is about (CHE and self-employed midwife (2): 10.5.94)

The partnership model is not an easy thing to put into practice. As a domino midwife I find that women feel they can make far greater demands on me as a health professional than they ever would of doctors. They expect me to be available 24 hours a day for their entire pregnancy and don't appreciate that there are times when I am not on call and they should contact another midwife in the practice (Domino midwife: 5.9.94).

Differing understandings of partnership arose from differences between groups of midwives with respect to factors such as background/training, work experience, and relations with colleagues, other health professionals and clients (Tully, 1994). While some independent midwives had considerable domiciliary experience, and a lengthy association with home birth consumers/activists, the majority were relatively new to self-employment and maternity consumer politics. For some of these midwives, whose training and work experience had been influenced by a more 'medicalised' approach to birthing, the 'partnership' model of practice presented a challenge to their understandings of an appropriate professional/client relationship. Of particular concern,

was the idea of partnership at the collective/organisational level between midwives, as health professionals, and maternity consumers, ie. non-professionals.

Concern about a lack of commitment to the partnership model of practice by some self-employed midwives was articulated by several maternity consumer representatives who had been involved in the struggle for autonomy and direct entry and who were prominent in the NZCOM. In a forthright address to midwives attending the third national conference in Rotorua in 1994, Judi Strid claimed that the enthusiasm with which midwives had individually "seized any and all windows of opportunity" had alienated them from the partnership that made them strong.<sup>27</sup> It had also, she claimed, got in the way of collective co-operation and collaboration among midwives (Strid, 1994: 92). Strid's primary concern was the lack of commitment to partnership with women as maternity consumers with an interest in the planning and implementation of maternity services.

... partnership is more than a good relationship at a personal level. It is about including women at all levels particularly where decision making takes place. A policy or protocol decision may have as much impact on a woman's options as it does on a midwife's scope of practice - often more. There is a need for women to have meaningful input into the planning, implementation and monitoring of maternity services... Midwives can help by emphasising and advocating the importance of consumer input and by making sure representatives from women's groups are included in matters relating to childbirth and other related issues (Strid, 1994: 97).

The president of Parents' Centre, Sharron Cole, was equally damning of some independent midwives' practise in an article in the organisation's national magazine. She claimed that some midwives were ignoring the philosophy and standards of practice of the NZCOM and were "trampling on the rights of women to quality

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<sup>27</sup> Strid had chaired the direct entry midwifery taskforce (as discussed in chapter four). In 1994 she was a consumer representative on the advisory committees for both direct entry programmes and was involved with the midwifery standards review process.

maternity care" (1994a: 5-6). She accused these midwives of practising like doctors who offered an "assembly line" maternity service and about whom consumers had been so critical. Some of these midwives were carrying caseloads of 12-15 clients a month despite the college's recommendation of 5-6 cases a month. Another maternity consumer representative, who was involved in reviewing standards of independent midwifery practice in Christchurch, was also critical of some midwives' high intervention rates (Interview: 14.12.93).

Prior to 1990, the midwives and maternity consumers/activists involved in the struggle for midwifery autonomy and direct entry training were united in their resistance to medicalised childbirth (as discussed in chapter three). However, as a consequence of midwifery autonomy and health sector restructuring, doing 'partnership' had become considerably more complicated. Within the college it basically involved a small number of consumer representatives, who were associated with either home birth associations, Parents Centre or La Leche League, collaborating with midwives who (a) had differing birthing philosophies and practises, (b) held differing views on the value of consumer involvement in their professional organisation and concerns and (c) had the benefits, in terms of status and financial rewards, of autonomous health professionals.

Instead of involving two philosophically aligned and mutually dependent groups, it now embraced a range of differently positioned practitioners and consumer representatives with potentially different understandings of what normal childbirth, continuity of care, partnership and so on involved. As noted earlier, some practitioners believed that it was appropriate for midwives to be involved in a partnership on a one-to-one level, ie. with their individual clients in the birthing process. However, they were sometimes reluctant to support a partnership at the collective/organisational level between midwives, as a group of health professionals, and maternity consumer

representatives, whom they regarded as only representing the interests of women with a particular orientation to birthing.

Of particular concern to some of these midwives was the involvement of consumer representatives in such areas of professional activity as the standards review committees, that monitored the practice of self-employed midwives. For some practitioners it was inappropriate to have consumers, or lay people, sitting on these committees and making judgement on their professional philosophy and practice. For example, some midwives who shared care with obstetricians believed that a review of their practice was inappropriate without the specialist being involved as he/she was the primary practitioner (Interview: 10.5.94). While they saw value in the review process as a means of ensuring that they were practising safely, from their experience the focus was on promoting a particular birthing philosophy with which they were not comfortable.

Despite opposition from some practitioners, the standards review process was seen by many associated with the NZCOM as the most important aspect of the midwife/consumer partnership. This was because it provided an opportunity for maternity consumers and midwives to work together to achieve professional standards that potentially enhanced the birth experience for women and consolidated the practice of midwifery as responsive to consumer concerns. The effort involved in making the partnership model work, at both a practitioner/client and an organisational level, had professional rewards in a context in which a quasi-market model of health care prevailed. With state actors intent on promoting consumer-oriented maternity services, establishing strong links between the NZCOM and consumer organisations definitely had advantages.



The final section of this chapter looks at some of the consequences for 'independent' midwifery of the introduction of the Section 51 Maternity Notice in mid-1996 (as discussed in chapter five). This section begins with a personal account of my involvement in the birth of a close friend's second baby in December 1998. Having helped with the delivery of her first child three years previously, I was pleased to again be asked to provide support. Being a support person at someone's birth is a real privilege. In this case, it was also a research opportunity. Participating in this hospital birth gave me a chance to observe some of the changes in birthing and postnatal practices resulting from the introduction of a lead maternity care (LMC) provider and fixed-fee maternity funding.

## 6.6 'Independent' midwifery post Section 51

*In December last year I attended my first midwife-only birth. While my friend Jude and her husband had opted for shared antenatal and birthing care for their first baby, their general practitioner no longer provided intrapartum (labour) care. This meant that she could be the LMC for the first two trimesters, providing the antenatal care to 28 weeks, but would then hand over the LMC role to the independent midwife, Chris, with whom she had previously shared Jude's care. Her care would resume six weeks after the birth with the mother/baby check.*

*Jude's second birth was as normal and relatively straight-forward as her first. On each occasion she laboured at home for some hours before going - as per the domino birth plan - to the base maternity hospital. Once settled into a labour ward birthing room she was soon swept headlong into the physical and emotional rollercoaster of the birthing process. With guidance and reassurance from Chris - and plenty of*

*brow mopping from her husband and me - she reached second stage without the need for pain relief.*

*As the urge to push became overwhelming, Chris assumed a more active role advising Jude on how to make the most of the powerful contractions. With patience and the voice of experience, she guided her client through the intense final stages leading up to the crowning of the baby's head. In contrast to Jude's first birth, Chris did not have to make way for the general practitioner shortly before delivery. When the need arose for an episiotomy - as it had in the previous birth - this highly skilled midwife did not have to hand the scissors over to a doctor.*

*After the birth Chris consulted with an obstetrician, with whom she frequently shared care, about suturing. While she had no qualms about doing the internal stitches, she felt it was more appropriate in this case for a specialist to stitch the perineum. After a quick phone call to adjust his frantic pre-Christmas schedule, he duly carried out the procedure. While Jude had to put up with further discomfort, I had the pleasure of cuddling her second daughter.*

*Within several hours of the birth, it was time to transfer out of the base hospital for postnatal care in a quieter, more comfortable environment. Again the options were different second time around. Instead of moving to a small, low-tech hospital birthing unit on the outskirts of the city, Jude took advantage of the opportunity to access formerly private maternity hospital facilities free of charge. Like many other new mothers in Christchurch, she opted for three nights at St George's Hospital in Merivale.*

*On arrival at St Georges we were shown to the last available single room. Situated on the ground floor of the hospital, with a sliding door to the terrace and gracious shady gardens, it was not hard to understand why this had become such a popular postnatal destination. A staff midwife served us cool fruit juices and a snack before finishing her morning shift. She and other midwives on duty in the unit over the weekend provided postnatal care in conjunction with Chris.*

*As Jude's LMC provider, Chris was responsible for her care until six weeks after the birth. Being a second-time mother with no breastfeeding difficulties, Jude proved to be the ideal client. Weekly home visits for the first month were sufficient to ensure that everything was going smoothly. At six weeks it was back to the general practitioner for a mother/baby check and the transfer of baby's care to the well-child provider, in this case Plunket.*

*Several months after Holly was born Jude had the chance to tell the Government what she thought of the new maternity system. She and other women who had given birth since the LMC system was introduced were invited to complete a questionnaire to indicate how satisfied they were with the new maternity arrangements. This questionnaire, along with submissions from health professionals, was part of an independent review of maternity services undertaken by a National Health Committee.*

The introduction in mid-1996 of the Maternity Section 51 Notice had major consequences for independent providers of primary maternity services in Aotearoa/New

Zealand. Central to this national collective contract was the introduction of a lead maternity care provider (LMC) who held the capped budget for a client's care. In shifting from fee-for-service to a fixed-fee funding arrangement, this contract encouraged the provision of a package of primary maternity services by a single practitioner. Where other practitioners were subcontracted to provide components of a client's care, the LMC was responsible for meeting the cost of those services.<sup>28</sup> Thus the LMC, rather than the purchaser/state, now held the financial risk involved in providing primary maternity services.

An important outcome of this policy change was the withdrawal of a large number of general practitioners from the provision of primary maternity services (as discussed in chapter five). With fewer doctors offering antenatal and labour care, self-employed midwives had an opportunity to assume a greater role in the provision of independent primary maternity services. For some midwives who had provided shared care in conjunction with particular general practitioners, the introduction of the LMC provisions of Section 51 was a catalyst for reconsidering how they practised. For example, a 'shared care' midwife who was quoted earlier in this chapter found herself assuming the legal/contractual responsibility for a client's care and feeling uncomfortable because the doctor, with whom she had worked so closely for several years, was becoming redundant.

I would sign the woman up and become her lead maternity care provider. I always felt I was responsible before but I felt it was a joint responsibility. Once Section 51 came in I felt totally responsible for the clients' wellbeing and ensuring they were referred appropriately. So I had to move on... I wanted to move on and obtain an epidural certificate so as not to have to hand over to clinic care when things became complicated. So I could retain the midwifery care but consult with an obstetrician. He

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<sup>28</sup> A copy of the Maternity Payment Schedule (MPS) for single service episodes and lead maternity carer modules is included in the appendix. Details of the payments were given in chapter five.

(the GP) couldn't come with me really - he got left behind (Former 'shared care' midwife: 2.12.98).

This midwife's shift from shared to full midwifery care as a consequence of the LMC arrangements shows how changes in funding/contracting regimes can significantly shape opportunities for autonomous practice. As a midwife with a commitment to shared care as a maternity option, she had resisted pressure from colleagues in the NZCOM to provide predominantly midwife-only care. An important catalyst for her move to assuming full responsibility for client care, ie. enhancing her professional jurisdiction, was the change in payment and contracting arrangements. As the practitioner who had been providing most of the clients' care throughout pregnancy, birth and postnatally, she was effectively fulfilling the role of the LMC already. Section 51 provided an incentive to formalise that role and be paid accordingly.

For independent midwives who continued to be involved in forms of shared care, the new payment system required that they negotiate with general practitioners over the terms and the costs/value of their respective input into a client's care.<sup>29</sup> With the constraints of a capped budget, both practitioners had to agree on what their respective share of the maternity care was worth.<sup>30</sup> Independent midwives I interviewed said they found the hassle of trying to organise payment arrangements outweighed any benefits to be gained from providing shared care.

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<sup>29</sup> A common form of shared care, which developed prior to the introduction of Section 51, was the involvement of a general practitioner up until the end of the second trimester (28 weeks). Under the maternity benefit system, practitioners could provide - and claim for - alternate antenatal consultations. With the introduction of modular funding, it was more common for general practitioners who provided antenatal care to be the LMC for the first two trimesters and then hand over the LMC role to an independent midwife (as was the case with Jude's care).

<sup>30</sup> One of the roles of the MPOs, as outlined in chapter five, will be to negotiate fees for the midwifery services involved in shared care with medical IPAs or similar organisations. The aim is to depersonalise the fee negotiation away from the individual midwife and doctor providing the service while protecting midwifery's control of midwifery's income (Guilliland, 1998).

Section 51 caused a greater rift between GPs and midwives - because midwives won't do shared care in the way that they used to because there is always the query, the discussion and the conflict over payments. Doctors want much more than we regard as fair given what we are left with from module payments (Self-employed midwife: 26.11.98).

Negotiating each practitioner's share of the labour/birth module was seen, not surprisingly, as the most difficult issue. According to the midwives I interviewed, the modular payment system paid only for basic, routine care. If they provided independent care to a woman who laboured very quickly and easily, they "came out ahead" financially. However, if that same woman then had considerable difficulties with breastfeeding, there was no extra funding to cover the additional postnatal care required. If a woman had a lengthy labour, there could even be difficulties paying for midwifery back-up. While the midwives recognised that it was a 'swings and roundabouts' payment system, with module fees sometimes providing for more care than a client required, their experience of Section 51 was a substantial drop in their incomes (Interview: 26.11.98).

In order to work within the financial constraints of a fixed-fee system, some independent midwives reduced the amount of antenatal home visiting they did and offered more care through clinics. Without separate reimbursement for mileage, they had to seriously consider where a prospective client lived and the financial viability of providing her care. This was particularly an issue for home birth midwives given the number of home visits that they provided postnatally (daily visits for the first five days following a birth, three visits in the second week, weekly visits for the third and fourth weeks and a final visit at six weeks). A home birth midwife told me (Interview: 26.2.98) that her practice had a lot of rural clients prior to the introduction of Section 51, but under the new payment system there had to be a few rural clients living in close proximity to make the service financially viable.

Another consequence of a fixed-fee funding arrangement was that it could provide a financial incentive for some independent midwives to take on the role of LMC but focus on labour support and provide as little antenatal and postnatal care for clients as possible. By increasing their caseload to 10 or 11 clients a month, and collecting more birth module payments, these midwives could significantly boost their incomes.<sup>31</sup> However, in a context in which there was increasing competition from both hospital-based midwives and other independent midwives for a share of the primary maternity market, they ran the risk of losing clients who became aware that they were being short-changed. Women who were dissatisfied with their care could ask another practitioner to take over as their LMC, as an independent midwife explained:

... we get a lot of phone calls from women who are due in three or four months and have midwives with huge caseloads. They will ring us in tears because they are desperate to find a new midwife. Their midwife is too busy and does not have time for them. They have compared notes - talked with other women who are receiving a service that is up to scratch - and they've suddenly realised that they are missing out (Self-employed midwife: 26.11.98).

Delivering a primary maternity service that was "up to scratch" in terms of consumer expectations was no longer just the concern of self-employed midwives and relatively few general practitioners. With the entry of hospital and private birthing centre providers into the primary maternity market (the focus of the next two chapters), there were considerably more options for maternity consumers to choose from. As hospitals took advantage of the opportunities created by Section 51 funding to introduce services

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<sup>31</sup> Practitioners who provide an inadequate number of services may be caught by HBL, the company that administers the primary maternity payments. HBL does comprehensive case reviews on randomly selected practitioners to monitor the claims they have made. If monitoring showed that a particular midwife did not, for example, do more than two postnatal visits for any of the cases investigated, she would be reported to the HFA for not meeting service specifications. An HFA survey of births between February and April of this year showed "significant underservicing" by midwives in relation to postnatal home visits (*New Zealand Doctor*, 21.7.99).

organised around an independent model of midwifery practice, self-employed midwives found themselves competing with their hospital-employed colleagues, rather than general practitioners, for clients. The challenge in the late 1990s was to provide a better service than that being offered by other groups of midwives, as this comment from the manager of Burwood Birthing Services, Chris Hendry, highlighted:

With Section 51 you do have to be a good practitioner, you have to offer a good service, a service better than anybody else. I believe it does push competition and I don't think that is a bad thing. Because women can vote with their feet you, as a practitioner, are going to have to provide the best possible service. Gone are the days when the midwife drops the woman postnatally - I mean hardly sees her - because she is not going to get the woman back. The chances are that the woman next door had a midwife who popped in and saw her quite a few times and called in for a cup of coffee on her way past. That midwife is going to get the on-going business (Hendry, Interview: 15.4.97).

## **6.7 Midwifery and obstetrics: complementary jurisdictions**

This chapter provides an account of how particular forms of professional practice involving independent or self-employed midwives have developed over the last decade. In tracing the emergence of various forms of practice, involving different combinations of practitioners located in and across a variety of sites, it highlights the contingency of this category of midwifery identity. What it means to be an 'independent' or 'self-employed' midwife in Aotearoa/New Zealand in the 1990s depends very much on the network of professional and client relations in which these practitioners are embedded and the discursive resources through which they constitute themselves and their practice. As these relations, discourses and practices shift and change, so do the meanings or identities that constitute this category of midwife.

Analysis has shown how midwives who embarked on new forms of 'independent' practice positioned themselves differently vis a vis general practitioners, obstetricians



and clients. As newcomers to self-employment, these midwives needed time and opportunities within the market to establish themselves as a maternity care option. Providing shared care with general practitioners enabled some midwives to build up professional confidence and a client base relatively quickly - even if it also constrained their practise. Providing shared or, more importantly, complementary care with obstetricians was a longer term strategy which had the potential to help consolidate midwives' status as specialists in the provision of 'normal' birthing services (or, for some midwives, the 'normal' component of obstetric services).

Shared care between midwives and general practitioners proved to be an unstable form of practice for a number of reasons. As primary health professionals with overlapping jurisdictions, midwives and general practitioners were inevitably competing for the same clientele. While some practitioners endeavoured to foster collaborative relations, differences in approaches to birthing and forms of service delivery meant that doing shared care often involved professional compromises. Making these compromises may have been in general practitioners' interests because they relied on midwives supplementing their maternity care. However, as midwives did not require input from general practitioners to provide care, they did not have a vested interest in making such an arrangement work. As fewer clients opted for shared care, midwives had even less reason to provide it.

Another factor that contributed to the decline of shared midwife/general practitioner care was the change to the system of funding primary maternity services. While fee-for-service facilitated the involvement of two practitioners in a client's pregnancy and birthing care, a fixed-fee system provided a financial incentive for one practitioner to assume responsibility for providing a package of services. As practitioners who offered continuity of care throughout the pregnancy, birthing and postnatal experience, self-employed midwives were obviously better positioned to assume this role than general

practitioners. However, while the new funding arrangement was a catalyst for more general practitioners to exit the maternity field, it should be recognised that this shift away from doctor involvement in the provision of primary maternity services was already well underway.

Despite difficulties that may arise in relations between particular self-employed midwives and obstetricians, cooperation between midwifery and obstetrics emerges in the reconfigured maternity field as a potentially more stable form of shared maternity practice. As specialists in primary and secondary maternity services, midwives and obstetricians have complementary rather than overlapping jurisdictions. Independent (and hospital employed) midwives need obstetricians to consult and possibly take over care in difficult cases, while obstetricians have to rely increasingly on midwives for referrals. With policy changes that locate the bulk of maternity work in the primary health sector, midwives have become gatekeepers to other maternity services. This mutual dependence means that it is in both professions' interests to provide/offer complementary expertise.

This chapter has demonstrated how various forms of professional practice involving independent or self-employed midwives have evolved out of changing relations between different groups of practitioners and clients in the maternity field. The opportunities that self-employed midwives have had to consolidate their position as independent or autonomous primary maternity practitioners have been an outcome of policy changes at a national level and responses to these changes by groups of practitioners and consumers at a local level. Without general practitioners deciding to withdraw from maternity work, and maternity consumers choosing to have independent midwifery care, self-employed midwives would not have had the same opportunities to pursue their professional interests.

Another 'local' response to maternity funding policy changes, which had an impact on self-employed midwives' opportunities for practice, was the development of continuity or caseload midwifery services in some public hospitals/CHEs. Chapter seven examines how the introduction of fixed-fee funding for primary maternity services gave some hospitals both an opportunity and a financial incentive to reorganise their midwifery services in order to compete with independent contractors for a share of the market. As providers that offered both medical and midwifery services, and controlled the access of independent practitioners to birthing facilities, public hospitals entered the competitive maternity market with some distinct advantages.

## Chapter Seven

### Birthing as a primary/secondary business

... we've become a lot more flexible in how we do our business. We've tried to be flexible around the woman. When we first set up we were very midwifery oriented because we wanted to provide the ideal midwifery service according to the philosophy of midwifery. What I think we've done is moved along with women and we've now become women-centred in how we offer our midwifery. We recognised that some women want a doctor involved, some women want to birth at Christchurch Women's, some women want their partner to deliver the baby, some want so many antenatal and postnatal visits or whatever...

- Practice Manager, Burwood Birthing Services: 15.4.97

#### 7.1 Introduction

As a consequence of the Nurses Amendment Act and the restructuring of health services, state actors introduced a significant new competitor into the primary maternity market. While some public hospitals/CHEs had offered primary maternity services in the past, their role had been limited to providing a facility staffed by midwives which was used primarily by general practitioners to supplement their care.<sup>1</sup> With the introduction of a competitive model of contracting into the primary maternity sector, hospitals/CHEs had both an opportunity and a financial incentive to reorganise their midwifery services to compete with independent contractors for clients. While some

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<sup>1</sup> Public hospitals became known as Crown Health Enterprises or CHEs with the implementation of health sector restructuring in 1993. They became 'hospitals' again late last year.

hospitals chose to exit primary maternity care, others saw the introduction of continuity or caseload midwifery services as a new 'business' opportunity.<sup>2</sup>

By employing midwives to provide on-call care to a caseload of clients, either in their own right or in conjunction with medical practitioners, hospital obstetrics managers could achieve a number of goals. Firstly, they could stem the tide of experienced midwives who were leaving hospital employment to embark on independent practice. For those hospital-employed midwives who were keen to provide continuity of care, the introduction of case management offered an alternative form of professional practice. Secondly, the managers could attract more primary maternity clients (and their funding) into their hospitals. By offering a service in which hospital-based midwives provided continuity of care, hospitals could compete with self-employed practitioners for a share of the primary maternity market.

With the introduction of a fixed-fee payment system for primary maternity services in July 1996, the provision of continuity/caseload midwifery from hospitals became an even more attractive financial proposition.<sup>3</sup> As primary maternity centres, hospitals providing continuity of midwifery care could be contracted by an RHA as lead maternity care providers (LMCs) and capture the extra revenue streams for the various modules of care. With the state paying a set fee per delivery/case, there was a financial incentive for attracting more primary maternity business. More births meant more income and a greater contribution towards a hospital's high level of fixed costs.

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<sup>2</sup> For example, hospitals in Rotorua, Tauranga and Wellington withdrew from providing primary maternity services to concentrate on secondary and/or tertiary services. In Wellington, the CHE Capital Coast Health withdrew from primary care following the establishment of a large independent provider organisation, Matpro, which has a contract with the Health Funding Authority to provide most of the primary maternity care in the city.

<sup>3</sup> Detailed discussion of the introduction of Section 51 of the Health and Disability Services Act 1993 is contained in chapter five. This legislation, which set out the terms and conditions under which the RHAs would purchase primary maternity services, came into effect on July 1, 1996.

Introducing continuity of care services involved a radical re-organisation of how some hospital-employed midwives practise. Instead of working rostered eight-hour shifts providing birthing care to women who present in labour ward, continuity midwives provide on-call care to a caseload of clients. Like their self-employed colleagues, they provide care throughout the client's pregnancy, birth and up to six weeks postnatally. While the birth usually takes place in the hospital, antenatal and/or postnatal care may be provided in general practitioners' rooms or the client's home. Again like their self-employed colleagues, continuity midwives may provide all the care themselves or share aspects of it with the client's general practitioner or obstetrician (who may be involved as a private consultant or a hospital specialist).

With hospital-based midwives providing care in the community, often in collaboration with medical practitioners, this new form of midwifery practice blurs the institutionalised boundaries between primary and secondary/tertiary maternity services. Organised within and across hospital/CHE boundaries, this way of doing midwifery work has more in common with an independent/domino model of practice than that associated with traditional hospital-based services.<sup>4</sup> While the adoption of this model means there is less of a distinction between services provided by some CHE-employed and self-employed midwives, thereby reducing the differences between some groups of midwives, it also means that there is greater competition between these groups for clients.

There is also intense competition between the various public maternity hospitals or birthing units for a share of the primary maternity market. While the introduction of continuity/caseload midwifery services has been a common strategy, how these

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<sup>4</sup> DiMaggio and Powell (1991) discuss the increasing homogeneity of an organisational field. They identify normative isomorphism as the mechanism through which this change occurs in relation to professionalisation. Two important sources of isomorphism are the resting of formal education and legitimation in a cognitive base produced by university specialists and the growth and elaboration of professional networks that span organisations and across which new models diffuse rapidly.

services are organised and provided differs according to the hospital and the position that it occupies in the field of medical/maternity providers. This chapter highlights such differences in examining the introduction of continuity of care midwifery in two Christchurch public hospitals. Drawing primarily on interviews with practice managers and midwives at Burwood and Christchurch Women's Hospitals, it shows how new forms of professional practice can be developed at the intersection of specific funding regimes and particular institutional arrangements.

## **7.2 Setting the context**

Before introducing the two hospital-based midwifery services featured in this chapter, it is important to consider the new market relations within which these hospitals - and other providers of public and private health care in Aotearoa/New Zealand - are now embedded (Granovetter 1985; Granovetter and Swedberg, 1992). As chapter five outlined, the reforms introduced by the National Government in the early 1990s established a split between the purchaser and providers of health services and managed competition between providers (Scott, 1994; Ashton, 1995; Fougere, 1994b, 1997; Cumming and Salmond, 1998). This competition took the form of a 'quasi' or internal market within health care, with contracts between the purchaser and providers governing the supply of services. By fostering competition between a range of providers, the Government hoped to ensure better use of resources and make health care more responsive to consumers (Upton, 1991).

According to economists (Le Grand and Bartlett, 1993), quasi-markets differ from conventional markets in a number of important ways. On the supply side, as with conventional markets, there is competition between productive enterprises or service suppliers for customers. However, in contrast to conventional markets, these organisations are not necessarily out to maximise their profits nor are they necessarily

privately owned. Precisely what the non-profit enterprises have as their objectives is often unclear, as is their ownership structure. On the demand side, consumer purchasing power is not expressed in money terms in a quasi-market. Instead, it either takes the form of an earmarked budget or 'voucher' confined to the purchase of a specific service allocated to users or is centralised in a state purchasing agency.

In the Aotearoa/New Zealand context, the quasi-market in health involves a monopsony as there is only a single purchaser.<sup>5</sup> This puts providers under added pressure to be competitive because the purchaser is able to threaten to withdraw a contract and place it elsewhere (Hudson, 1994). In the primary maternity sector, the purchaser (now the HFA) does not guarantee a contracted provider a share of the market.<sup>6</sup> This means that competition is not so much for contracts for payment as for clients. It is up to the various providers to secure the number of clients that they need to cover their costs. This arrangement intensifies competition for clients and ensures that it is the providers, rather than the government/purchaser, that carry the financial risks associated with providing primary maternity services.

Like other regulated markets, the quasi-market in health is created through legislation and is subject to changes occurring as a result of strategic policy choices (Hughes et al., 1997). These policy changes can have major consequences for both professional groups and organisations competing for contracts and/or clients within particular sectors of health care. In the primary maternity sector, the shift to competitive contractual relations was followed by the introduction of a national, collective contract

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<sup>5</sup> Plans to introduce alternative non-government purchasers, called Health Care Plans (HCPs), were shelved following intense opposition from health professionals and consumers (as discussed in chapter five).

<sup>6</sup> At the time that these policy changes were introduced, there were four government health purchasing agencies called Regional Health Authorities (RHAs). In 1997 they were amalgamated into a single purchasing authority which, in October 1998, became known as the Health Funding Authority (HFA).



(Maternity Section 51 Notice).<sup>7</sup> This contract, which is the basis for other contracts negotiated with provider groups/organisations, established a global or capped budget for the provision of a package of primary maternity services. In getting rid of fee-for-service, this contract advantaged some provider groups (including hospitals/CHEs) more than others.

### 7.3 A Tale of Two CHEs

The two Christchurch public hospitals featured in this chapter occupy very different positions within the field of maternity services in Canterbury. Christchurch Women's Hospital is the high-technology base obstetric unit which caters for 3500 births annually while the Burwood birthing practice is a small, low-risk unit which handles approximately 500 births a year. The two hospitals belonged to different CHEs when they introduced continuity of care/caseload midwifery services.<sup>8</sup> Burwood Hospital, which was managed by Canterbury Health, is situated in a semi-rural suburb on the outskirts of Christchurch. The 200-bed facility provides a range of rehabilitation services including a pain management centre, a brain injury rehabilitation service and a respiratory unit. It is best known for its spinal injuries unit which was purpose built in 1979.

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<sup>7</sup> The Advice Notice is the contract which outlines the payment structure and fee schedule according to which the RHAs (now the HFA) purchased primary maternity services from midwives, general practitioners and specialists (as discussed in chapter five). While an organisation such as a CHE (or an IPA) can be contracted to provide these services, it is not able to claim fees via a Section 51 notice as this is the mechanism for funding independent providers. A separate contract, which incorporates most of the terms of the Section 51 Notice, has to be negotiated between the CHE and an RHA.

<sup>8</sup> The National Interim Provider Board, which was responsible for the corporatisation of large public hospitals and their related services into CHEs, divided the Christchurch-based hospital services into complementary rather than competitive business units. The rationale was that the population base did not warrant two CHEs competing for the same work. The inappropriateness of the two CHEs became a major local issue. See Malcolm (*The Press*, 31.7.96).

Historically, the Burwood maternity unit provided a low-technology facility for general practitioners and, since 1990, self-employed midwives whose clients chose to birth in a hospital which provided "safe and friendly surroundings".<sup>9</sup> The majority of women using the facility had experienced previous normal births, lived near the hospital, had general practitioners in the area and/or had midwives who used to work in the unit. A significant number of Maori women birthed in the unit (Hendry, 1996). While there were over 1000 births in the unit in 1989, numbers had subsequently fallen as general practitioners withdrew from obstetrics and women were encouraged to birth at the base obstetric hospital. In 1992, the Canterbury area health board considered closing the Burwood maternity ward and shifting its staff and services to Christchurch Women's Hospital (*The Press*, 15.4.92; *The Press*, 3.12.92).

While the Burwood maternity unit was struggling to attract bookings, Christchurch Women's Hospital was struggling to cope with the demand for its services (*The Press*, 20.11.93; *The Press*, 23.11.93). This level-three base obstetric hospital, which was initially part of the Healthlink South CHE but then joined Canterbury Health in December 1997, offers a full range of obstetric, gynaecological, neonatal and infertility services. Plans to relocate some of these services to Princess Margaret Hospital and close Christchurch Women's were announced by its former administrator, the Canterbury area health board, in 1991. By relocating the high-risk obstetrics, intensive care and neonatal services to another hospital, the board hoped to save more than \$1.7 million a year (*The Press*, 28.2.91). However, this plan was shelved when the board was replaced initially by a commissioner and then the National Interim Provider Board.

Of the two hospitals, Burwood was the first to offer a service organised around continuity of midwifery care. Plans for the introduction of a case management model of

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<sup>9</sup> There are no medical practitioners employed to work in the level one birthing unit at Burwood. Consultation and emergency referral services are provided by private obstetricians and paediatricians. However, being a general hospital there are the normal back-up emergency services of "on call" resident medical staff.

midwifery practice began in early 1994. This model involves CHE-employed midwives, including new graduates and more experienced staff, providing on-call care to a caseload of clients. This care may be provided in the client's home (including home births), a community facility and/or the birthing unit. Midwives who chose not to take on the responsibility of providing continuity of care became 'core midwives'. They continued to work eight-hour shifts providing back-up for the continuity and self-employed midwives using the unit.

Case management midwifery was introduced at Christchurch Women's Hospital in September 1995. This service drew on the original name of the hospital in being identified as the 'St Helen's one-to-one midwifery partnership'.<sup>10</sup> Using this name was significant in that it associated the new midwifery service with an era when hospital-employed midwives occupied a central position in the provision of maternity services. Midwives in the state-run St Helen's hospitals were recognised as providing a high standard of care for mothers struggling to raise families on small incomes (Mein Smith, 1986). The St Helen's midwives took responsibility for the care of pregnant/birthing women in a context where there was back-up or support from medical practitioners if required.

The value of having a one-to-one relationship with a midwife throughout the pregnancy and birthing experience but with the back-up of specialists and a high-technology facility is promoted in advertising for the service. According to publicity material, it offers women their own midwife and her small support team; a unique 24-hour backup support provided by specialist obstetricians, anaesthetists and paediatricians; epidurals, caesarean sections and paediatric services for newborn babies; and breastfeeding advice and support (both in hospital and in the comfort of her own home). The service

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<sup>10</sup> Christchurch Women's Hospital was built on its present site in Colombo St in 1952 but was not called by its current name until 1968 when it was given to the hospital board to run as a "pilot scheme".

involves a blurring of the boundary between primary and secondary maternity care in that staff employed in a high-technology secondary/tertiary facility are providing a primary service, complete with home visits and the occasional home birth.

The introduction of these services means that women who book into either of these hospitals for their births are given the opportunity to have midwifery care from the same CHE midwife (and her 'partner/s') throughout their pregnancy and labour. These midwives, like their self-employed counterparts, provide either midwife-only care or share aspects of that care with a medical practitioner. The practice manager for Burwood Birthing Services, Chris Hendry, explained how the continuity of midwifery care scheme at Burwood operates:

When a woman books into us we send a letter to her GP and a letter to the woman. We thank her for booking with us and explain that we offer a continuity of midwifery care scheme here so that every woman who books in knows the midwife who will attend her when she comes into labour or will go to her home in early labour. So every woman coming into the unit, if she doesn't have an independent midwife, will have one of our midwives. The letter says that one of the midwives will be contacting her and arranging to meet her a couple of times before the birth (Hendry, Interview: 21.10.94).<sup>11</sup>

This contact with the woman was made at about 28 weeks when the midwife introduced herself and invited the woman to visit the unit and discuss what she wanted for her birth. Arrangements were then made with the woman's general practitioner if the midwife was going to either share the antenatal and birthing care or provide aspects

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<sup>11</sup> Chris Hendry was appointed practice manager at Burwood in August 1994. Prior to this appointment she was involved in establishing a postgraduate midwifery course for registered nurses at the Christchurch Polytechnic. A strong advocate of midwifery autonomy and professional accountability, she saw her task at Burwood as one of manager or facilitator rather than clinical specialist. It should be noted that I interviewed Chris on two occasions about the continuity of midwifery care service at Burwood. The first interview was in 1994, several months after the service was introduced. The second interview was in 1997, almost a year after the introduction of the Section 51 funding arrangements.

of it on her own. When the service began it was common for women to have their antenatal care provided, often on an alternate visit basis, by the general practitioner and midwife but their labour care was midwife-only. This arrangement particularly suited the general practitioners who did not "do births" as they had less chance of losing their patient/client to a general practitioner who provided delivery care. As Hendry explained:

What has happened previously is that doctors who don't do births either fob the women off to Christchurch Women's where they attend the clinic or they go to a GP who does births. Their own GP takes the risk that the woman will form a relationship with the other doctor and decide to stay with them. So by sharing care with the midwives those doctors don't risk losing their clients to other doctors and it allows the women to have continuity of care - so it kills two birds with one stone...There have been all sorts of arrangements that the doctors have made with the midwife and the woman and we are happy to fit in. It's just an arrangement between the midwife, the woman and the doctor really as to what sort of things we offer (Hendry, Interview: 21.10.94).

Early in 1997 several of the Burwood continuity midwives began running clinics in practices of local general practitioners who did not provide labour care. Their services were available to pregnant women in the practice who did not have their own independent midwife and who intended to birth at Burwood or transfer there postnatally (although they would also provide birthing care at Christchurch Women's if this was the woman's choice or necessary for clinical reasons). The doctor might have seen the woman a couple of times but the midwife assumed responsibility for the antenatal care after 28 weeks, the birth and postnatal care. According to Hendry, an attractive aspect of the arrangement for the general practitioners was that they could keep track of the woman's progress.

What the GPs have said is that it makes it easier communication-wise. If there are any issues they know who to contact. They do describe pregnant women as like going down a deep dark hole and turning up six weeks after the birth with a baby. The GPs may have done a pregnancy test and seen the woman a couple of times and

then wonder if she has continued with the pregnancy, or moved house or whatever, because a lot of times they are not told anything by the (independent) midwife or the woman. And they have been really concerned about whether everything is okay (Hendry, Interview: 15.4.97).

This willingness on the part of the Burwood midwives to complement the maternity care provided by general practitioners was understandable given the interdependent working relations the two groups shared in the past. As a low-tech birthing unit on the outskirts of the city, Burwood did not attract women who wanted the security of birthing in a hospital where a range of medical specialists and technologies were on hand. It therefore relied heavily on the support of local general practitioners who encouraged their patients to birth there. When the CHE midwives began providing continuity of care, they had limited access to new clients and again relied on practising in conjunction with general practitioners. This related to their position as employees within a maternity service which, primarily because of its location, had at various times struggled to attract sufficient business and been threatened with closure.

As noted earlier, a shortage of business was not a problem facing midwives at Christchurch Women's Hospital. A more pressing issue for the midwifery staff at this busy, central city hospital was the quality of the services they offered vis a vis other practitioners. According to the co-ordinator of the one-to-one service, English midwife Ann Corkin, one of the reasons for adopting a caseload model of midwifery care was to provide women with the type of care that they could receive from independent practitioners.

... we were offering care to women which wasn't equal to the care they could have got from an independent practitioner in their view. It was superior in terms of the facilities and the expertise - because we have the anaesthetists and the paediatricians - but women didn't want to come here mainly because the type of (midwifery) care they received was different to that provided by the independents (Corkin, Interview: 27.5.97).

The one-to-one service at Christchurch Women's Hospital began with 13 midwives providing care to clients on either an on-call or a 12-hour roster basis. Two midwives, including Corkin, chose to work on-call (24 hours a day, seven days a week) while the others opted for the roster (12 hours on-call, five days a week). However, the rostered midwives (who worked in two teams) found that they were spending a lot of time looking after each other's women which was contrary to the aim of the service. As Corkin explained:

When you were on call for 12 hours, instead of being on-call for those five women who were due for you that month, you were really on call for 20 women, who might just come into labour that month as well. So you looked after women that you'd met but didn't know. It wasn't very suitable for the women and eventually it became unsuitable for the midwives (Corkin, Interview: 27.5.97).

By June 1996, all but four of the midwives who were providing case management care were working on 24-hour call. By September of that year there was only one midwife who preferred to remain on a 12-hour roster but, as she had no-one to work with in a team, she had to join the others on 24-hour call. By July 1997, there were 21 midwives in the one-to-one service, each carrying a caseload of up to 52 women a year (an average of six to seven women each a month). They were organised into five teams of four which meant that, at any given time, there were three midwives from each team working and one midwife was rostered off. Each midwife spread her caseload over nine months and had three months off a year (not consecutive months). The team arrangement was necessary so that the midwives could provide backup for each other.<sup>12</sup>

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<sup>12</sup> A midwife who worked on the one-to-one service for just over three years before going into independent practice said the teams had a considerable degree of autonomy in terms of how they worked. Her team had been committed to providing as much continuity of care as possible and organised itself in much the same way as an independent practice.

The one-to-one midwives provided midwife-only care or shared antenatal and/or birthing care with a hospital obstetrician. They may share a woman's antenatal care with her general practitioner (up to 28 weeks) but not her birthing/labour care. In contrast to the arrangement at Burwood Hospital, women who opted for shared general practitioner and midwife care had birthing or labour care provided by 'core' midwives working in labour ward rather than a continuity midwife with whom they had established a relationship throughout the pregnancy. The one-to-one service was set up to attract clients away from independent midwives.

At both Burwood and Christchurch Women's hospitals, the on-call midwives worked alongside those hospital/CHE midwives who continued to work rostered eight-hour shifts to cover 'core' duties in the unit or labour ward. At Burwood these 'core' midwives provided back-up support for both continuity of care and self-employed practitioners who accompanied women in labour. The 'core' midwives at Christchurch Women's Hospital were called on less as backup for the one-to-one midwives than their counterparts at Burwood because of the team arrangement. Also, being employees in a base maternity hospital, their services were required for women birthing in labour ward. These women could be patients/clients of a general practitioner or obstetrician who was not sharing labour care with an independent midwife. They could also be clients of an independent practitioner whose care, for some clinical reason, had to be handed over to the hospital's medical and midwifery staff.<sup>13</sup>

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<sup>13</sup> Negotiated shared care between self-employed midwives and hospital midwives has been advocated by the national director of the NZCOM, Karen Guilliland (1998: 146). She would like to see hospital midwives take over the LMC role for labour and birth when, for example, a woman from a rural area chose, or was advised to use, base hospital services. Guilliland said this form of shared practice could enable a rural woman, with a condition such as a breech-position baby or a previous caesarean section, to be cared for by a midwife in the base hospital with its medical support systems. The woman could then return to the care of her rural LMC midwife. This form of practice would "strengthen the difficult role" of the 'core' midwife by giving her input antenatally or postnatally if required and recognising her skills.



This highlights the emergence of different categories or types of midwife who share the status of CHE/hospital employees but who work in different relations with clients and who receive different rewards, both in terms of income and job satisfaction, for the work that they do. These differences are not simply those between caseload/continuity and core midwives because how those categories are constituted also differs according to the organisational arrangements in the hospitals within which the midwives are working. For instance, Chris Hendry was determined to enhance the 'core' midwife's role in the Burwood practice:

The core midwife is the second pair of hands in for the birth if you (the independent or continuity midwife) need it. She's the person you can confer with if you need another midwife to discuss something with. She's the midwife who will follow your plan of care which you write up every day after you've done the postnatal check. She's not the lucky who is used to clean up after the birth and so on (Hendry, Interview: 21.10.94).

With all women birthing in the unit having their midwifery care provided primarily by either independent or continuity midwives, the core midwives have less involvement in labour care than they had prior to the Nurses Amendment Act and the reorganisation of midwifery services. However, it was their provision of rostered midwifery care that enabled the other practitioners to work in an independent capacity within an institutional birthing unit/facility. Without the 24-hour cover provided by these midwives, the continuity/independent midwives and general practitioners would have to provide all the postbirth and postnatal care themselves. This could be difficult with the demands of other clients and/or a general practice.<sup>14</sup>

Prior to the introduction of continuity/caseload midwifery in the CHEs, some of the independent practitioners had come to expect CHE midwives to supplement the care

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<sup>14</sup> The demands involved in staffing a facility and providing 24-hour care to clients are discussed in chapter eight in relation to the Avonlea Birthing Centre.

they were providing by performing some of the routine and time-consuming tasks involved in labour/birth care. However, with the reduction in the number of midwives working in this 'core' capacity, the independent practitioners could not continue to offload these tasks onto CHE staff. An argument about the importance of continuity of care(giver) was advanced by Hendry to support the re-defining of the work done or, just as significantly, not done by the different groups of CHE midwives.

... the independent midwives saw immediately that they would have to do more for their women than they were currently doing. They couldn't just come in here, birth the woman and whizz out leaving our midwife to do the showering, helping with breastfeeding, the postnatal check and so on. We are encouraging continuity of care full-stop. If you deliver a woman, you take her to the shower afterwards, you settle her and the baby down before you go and do the paperwork. Our midwives were being used to clean up the room, clean up the trolley, do all that sort of stuff. No more. Our midwives do exactly the same as them (the independents). They stay until the end, until the woman is settled comfortably in her postnatal room and the admission is entered on the computer... It has changed toward genuine continuity of midwifery care meaning that you don't birth a woman in a facility and then drop her and pick her up again when she goes out. You give care to her while she is in the facility (Hendry, Interview: 21.10.94).

The tasks that constituted the work of the 'core' midwives at Christchurch Women's Hospital differed from those at Burwood for reasons that relate primarily to it being a base hospital which not only provided normal and abnormal obstetric care, but also provided these services on both a scheduled and an acute or emergency basis. Having to provide for the unexpected had an influence on both the numbers of staff required and the type of work that they did. Corkin described the work of core midwives at the hospital in this way:

Part of being the core staff at Christchurch Women's is there could be four of you on who need to do the work of eight because all hell breaks loose and it is all hands on deck. Or the four of you could sit there literally all night and have a good old natter, put the TV on and knit (Corkin, Interview: 27.5.97).

Another difference between the two CHEs is that the Burwood continuity midwives were expected to undertake some core duties when required. The request to cover a core shift for a midwife who was ill or on leave usually coincided with a quieter time in the continuity midwife's work schedule. This movement between the rostered and on-call roles highlights the fact that, while the continuity midwives in this unit practised as lead maternity care providers, ie. on the same basis as self-employed practitioners, they were CHE/hospital employees whose income was guaranteed by their employer.<sup>15</sup> As hospital employees they were subject to management demands on their time and services. Hendry made the business side of the maternity practice very clear to her midwives.

Our midwives are employed and they each cost me about \$56,000 a year. They are paid a regular amount every fortnight to be available to me 24 hours a day, seven days a week ... Each month I give each midwife a printout and she knows exactly how much she has earned for us ... The midwives basically know they have to earn more than \$56,000 from HBL (Health Benefits Limited) to cover their costs. And they know that if they don't then we are not going to look an attractive business and we are at risk. So I am very above board with all the finances here. You have to be (Hendry, Interview: 15.4.97).

To facilitate the hospital midwives providing on-call care to a caseload of clients required the rewriting of their collective employment contract. Negotiations between their CHE employers and the New Zealand Nurses' Organisation resulted in a variation to the nurses' contract to enable them to manage a caseload.<sup>16</sup> The provisions that were subject to variation included hours of work and pay rates (Slater, 1994: 11). For

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<sup>15</sup> While the continuity/caseload midwives practice as the LMCs under the section 51 funding arrangements, it is the CHEs that claim the funding from Health Benefits Limited (HBL) on the midwives' behalf.

<sup>16</sup> CHE midwives could belong to the NZCOM, their professional association, but were represented industrially by the NZNO. Midwives' employment on the same basis/contract as nurses was a legacy of the fact that midwifery had been constituted for decades as obstetric nursing.

example, rather than hours being calculated on a daily (eight-hour) basis, they were calculated over a 160-hour month to enable midwives to work up to 12 hours a day with a woman in labour. Where midwives worked in excess of 100 hours per fortnight (or 160 hours a month), they were not entitled to additional remuneration. Their salary package was approximately \$48,000 (for a caseload of 50 women a year) with additional allowances for vehicle use (\$3000), clothing dry cleaning (\$700) and NZNO/NZCOM fees.<sup>17</sup>

#### **7.4 From continuity to core and back ... new career patterns**

The development of these different forms of midwifery practice within hospitals has meant that midwives have greater choice and flexibility about how they want to work.<sup>18</sup> It is now possible to opt for a 'core' position if the demands of working on 24-hour call become too much. An advantage of working 'core' duties is that the midwife can work part-time. To provide continuity of care on a part-time basis still involves working on-call but for fewer clients. In the case of the Burwood unit, it has become common for midwives to move between these different forms of professional practice. A midwife who provided continuity of care for two and a half years and was now working in a

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<sup>17</sup> Midwives working on the one-to-one service at Christchurch Women's Hospital subsequently received additional remuneration for exceeding the required annual caseload for a fulltime continuity midwife of 50 women. According to the 1998-99 collective contract, full-time employees were entitled to a productivity payment of \$1000 for each case carried in excess of the basic caseload. This followed several years of negotiating unsuccessfully for a wage increase. An item in the August 1997 issue of the NZNO journal *Kai Tiaki* noted that the continuity midwives had not been offered a wage increase after almost two years of contract negotiations despite the scheme being "widely recognised as a success for the CHE and for local women".

<sup>18</sup> This flexibility can extend to working in both a hospital-employed and a self-employed capacity. Some midwives working in another low-risk hospital birthing unit in Christchurch chose to work part-time for the hospital and part-time as independent contractors after hospital management decided not to put extra resources into setting up a continuity of care midwifery service. As a consequence of not offering continuity, client numbers began to fall and the midwives feared that the unit would be closed. Their frustration with the situation was exacerbated by the fact that self-employed midwives practising in the area often chose not to support the midwife-run unit by birthing their clients at the base obstetric hospital. By offering both clinic and independent care, the midwives have been able to boost the number of births in the unit each month (up from 2-4 to 10).

core capacity, described how the midwives moved between these different ways of working:

When the system first started I think the midwives who were doing core duties felt they were missing out on a role that they had had previously - in that they weren't doing labour care. But now so many of us have swapped from one to the other and back we are all quite happy...You can move in and out from one role to the other - we do swap and take a few months off or whatever - so you get a break - because you can't provide continuity of care all the time. Like you couldn't do it for 30 years in a row without having a break because you would just get too exhausted. It is too much of a commitment (Core midwife: 15.4.97).

Working on-call for 24 hours a day, seven days a week ("you may get two days off a fortnight if you are lucky") was extremely demanding, especially for those midwives who had family commitments.<sup>19</sup>

The reality of that demand on your family is that you may walk out the door at the drop of a hat and you may not be back for 24 hours. And they never know whether you are going to be there in five minutes time... For the 10 days in a row that you are on-call - and sometimes it would even be three weeks in a row - there are lots of things that you can't arrange to do. Like you can't be the only one who takes your kids down to the swimming pool for their lessons because if your beep goes and you have to race off to someone in labour there is no-one to get them dressed and take them home again (Core midwife: 15.4.97).

While this form of midwifery practice was more demanding in terms of time and effort, it did provide the CHE continuity/caseload midwives with far greater job satisfaction than they had working eight-hour shifts. They identified the opportunity to develop a

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<sup>19</sup> A midwife who had a young family left the St Helen's one-to-one service after a year because she couldn't cope with the demands - particularly the phone calls during the night. Another two midwives left after about two and a half years - with one of them stating it was long enough to live with a pager. She chose to work on a postnatal ward for a year with the intention of then returning to on-call care. Professional workshops held at the Midwifery Resource Centre in Christchurch have focussed on "The Tyranny of the Pager".

relationship with a woman/client throughout her pregnancy as the source of this satisfaction.

It is more satisfying from the midwife's point of view because you used to do just an eight-hour shift. You'd look after someone when they came in in labour. You wouldn't know them. You might, if you were lucky, have met them in an antenatal clinic or something. But often it was someone you had never laid eyes on before and they did not know you. It wasn't as satisfying - it wasn't as demanding but it wasn't as satisfying either.

I can see that in a couple of years time... continuity will be an attractive proposition again because this (core work) is not as stimulating or as fulfilling because you do not get that relationship with women. They come in and they go out - you get to know them a little bit and then they are gone. You don't have that nine months of relationship. Midwives don't like missing their own women in labour because there is that relationship there. You look forward to a woman going into labour, seeing what happens, seeing the baby and being there (Core midwife: 15.4.97).

CHE midwives saw some advantages in providing this form of midwifery care from a hospital-based practice rather than an independent practice despite the fact that they could potentially earn more as an independent practitioner.<sup>20</sup> These advantages included the tasks performed by the core midwifery staff and the practice/obstetrics manager which made both clinical and business aspects of their practice easier. In the case of Christchurch Women's, continuity midwives received considerable back-up support from medical consultants who were easily accessed through the hospital clinic. This meant that they could take on clients that some independent midwives would not feel comfortable taking responsibility for.

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<sup>20</sup> Independent midwives earn approximately \$1000 per birth after expenses and tax whereas hospital-employed continuity or caseload midwives earn approximately \$1000 per birth before expenses and tax. For example, a percentage of the income that the continuity midwives at Christchurch Women's Hospital earn under Section 51 goes towards meeting the cost of various overheads associated with the one-to-one service including physiotherapy, social work and dietary services.

... if I was an independent practitioner and I wanted to look after six women a month then I would have to book eight because I would anticipate perhaps losing two. You might get someone with twins, a placenta praevia or gestational diabetes... and end up with four or five. You might also of course end up with the eight staying normal and having no problems so you then have to have the ability to look after them all. Whereas here...whatever happens to the women... we can keep them because we provide that sort of care (Continuity midwife: 27.5.97).

The midwives in the one-to-one scheme also had the advantage of being able to rely on midwifery staff in the postnatal wards to provide their client's care for two to three days following the birth (unless the client chose to transfer to another facility). Back-up from midwifery staff working in either core or clinic arrangements also meant that hospital-employed midwives could manage more clients per month than many independent midwives would consider appropriate. With core midwives in small units like Burwood being the first point of contact for client enquiries, the continuity midwives were also shielded from some of the demands on their time that independent midwives faced.

We are better off here than a lot of the independents because the women have to ring the birthing unit rather than beep their midwife directly. So a lot of the time the core midwife can answer whatever query they have. If it is something that is obvious and simple to deal with then you don't have to bother their primary midwife. Like you may have someone ringing up to say that they have colostrum leaking and they are wondering if that is normal or that the baby may not be settled in the evening. Well you can advise them on that without having to beep their own midwife. An independent would have to deal with those calls herself (Core midwife: 15.4.97).

With regard to the business aspects, the practice/obstetrics manager was responsible for dealing with such concerns as personnel, equipment, marketing and communications. An example of what this meant in practical terms for the midwives in the Burwood practice was the employment of a new continuity midwife in early 1997. Apart from having their say about the sort of person they thought would be most suitable, the

midwives did not have to worry about the appointment procedure. According to Hendry:

The midwives didn't have to worry about the advertisements - I showed them how we were going to do it. I showed them the job description to see if there was anything they wanted to change. I showed them the interview questions to see if there were any questions they wanted asked. I asked for one of the midwives to be involved in the interview. So they had all that input. They didn't have to worry about how many people applied. They had a general idea as to the nature of the people that applied. They gave me an idea of the sort of person they were looking for. And they made it clear to the midwife who was on the interview panel the sort of person they were looking for (Interview: 15.4.97).

As practice manager Hendry was also concerned about the hours that her on-call staff worked and whether they were doing too much - or too little. As noted earlier, she could request that they did a core shift if their on-call workload was light at a particular time.

I keep track of their hours spent on providing antenatal and birthing care, travel, meetings, everything and I write notes to them. I might suggest that they take it a bit quietly next week. Or I might notice that they haven't been doing too many hours lately and may request that they relieve a couple of duties for the core midwife. They know I do that and they are happy about it (Hendry, Interview: 15.4.97).

An advantage of this monitoring and management of the CHE midwives' hours was that the possibility of burnout due to overwork was reduced. However, from the midwives' perspective, it also meant that their control over what they did and when they did it was reduced. Given the unpredictable nature of on-call midwifery, it could be difficult for these midwives to meet the demands of both their clients and their employer.

The caseload is extremely variable. I had weeks when I might do 15 hours and others when I did 70. It could vary quite dramatically from one week to the next. If you are



having a quiet week and you have just had a busy week... as an independent (midwife) you might get some sleep and spend time with your family and catch up... whereas working on the continuity scheme you tend to get situations where you have someone on your back saying you are having a quiet week this week so how about doing a shift on Friday (Core midwife: 15.4.97).

While the continuity midwives in units like Burwood may not have had the same freedom as their independent counterparts to manage their downtime as they wished, they did have the benefit of a guaranteed caseload and a guaranteed income. With approximately 80 per cent of the women who attended the clinic at Christchurch Women's Hospital opting for a one-to-one midwife, there was no shortage of clients. For newly registered midwives, the hospital continuity schemes could be an attractive proposition. The midwife who was selected as a result of the appointment procedure described above was supplied with a pager, birthing pack, orientation folder and a caseload of clients on her first day on the job. In joining the Burwood practice she went from being a newly registered midwife (with a bachelors degree in midwifery from a direct entry training programme) to a practitioner earning over \$50,000 a year.

## **7.5 Funding regimes and hospital midwifery services**

This chapter provides an account of how new forms of midwifery practice are being organised in two public hospital/CHE sites. It highlights the development of a particular form of autonomous midwifery practice in which midwives employed by public hospitals, ie. secondary medical care institutions, can assume full or shared responsibility for the provision of primary maternity services to a caseload of clients. To explain how this form of CHE-based midwifery practice came about involves looking at policy changes affecting the funding and provision of primary maternity services. These changes dramatically altered the primary maternity field/market by introducing competition between providers and then specifying the type and cost of services that the RHAs would purchase.

Prior to the restructuring of health services in 1993, public hospitals were funded on the basis of population-adjusted, global budgets. However, reconfigured as CHEs, they no longer had an automatic claim on public funding (Fougere, 1997). Like private hospitals and primary care providers, CHEs had to depend on selling their services to the RHAs to gain an income. This change, coupled with the responsibility being put on RHAs to purchase all public health services within a region from a variety of public and private providers, meant that CHEs had an opportunity to contract for services that they had not previously provided. Hence, the chance to contract for primary maternity services which the RHAs purchased on a case by case (per delivery) basis according to the terms of the Maternity Section 51 Notice.

Contracting with the RHAs/HFA for the provision of services does not guarantee maternity care providers a share of the market. As funding follows the client, it is up to the providers to attract whatever clientele they need to generate the required income. From the RHAs/HFA perspective, competition for clients ensures that providers make available the type of services that clients' want, thereby ensuring consumer choice, and that expenditure on these services is controlled. It is of little consequence to the purchaser whether the various aspects of maternity care, including the birth, take place in a hospital, birthing centre or client's home. It is also irrelevant whether the services are provided by a single practitioner, who claims the total fee, or a sub-contracted practitioner, who claims a share of the fee.

What does concern the RHAs/HFA is that providers, whether they are independent contractors or organisations, endeavour to provide maternity clients with continuity of care throughout their pregnancy, childbirth and up to six weeks after the birth. Funding is organised around the expectation that a lead maternity carer (LMC) will take responsibility for ensuring that all appropriate services are made available to the client

throughout the various stages (as discussed in chapter five). Where CHEs are contracted to provide maternity services, a "suitably qualified and experienced" LMC has to be allocated to each client (Joint RHA S51 Maternity Review Project, 1995: 8). By purchasing "modules of care" on a fee per case basis, rather than items of service, the RHAs/HFA provides a financial incentive for providers to assume responsibility for a client's full care.

An outcome of these funding policy changes is that CHEs have both the incentive and the means to compete against other providers for a share of the primary maternity market. By employing midwives in such a way that they can assume responsibility for the provision of primary maternity services to a caseload of clients, the CHEs can position themselves as lead maternity care providers (LMCs) and access extra revenue streams from the RHAs/HFA. This means that, rather than being limited to income derived from facility or delivery fees, the CHEs can claim funding for the provision of antenatal, birthing and postnatal services to clients. Given that the fixed fee funding arrangement makes it more lucrative to provide this package of services rather than components of care, there is a financial incentive for CHEs to support a continuity/caseload form of midwifery practice.

While the CHEs that offer primary maternity services may share a financial interest in offering a continuity/caseload or client-centred form of midwifery practice, how they organise such a service varies. Like the independent contractors, CHEs have an interest in distinguishing their services from those of competing providers in order to secure a clientele. How they go about doing this is influenced by/contingent upon the material and discursive resources and sets of relations that they have to draw on from their particular location within the market. It is from different positions vis a vis clients, other practitioners, facilities etc that providers organise different ways of doing primary maternity work. These various ways of working, which are organised in and across a

variety of sites and around the skills/expertise of practitioners, are designed to appeal to different groups of maternity consumers.

In the cases discussed in this chapter, there are similarities and differences between the ways that midwifery work gets done in and from the CHEs which can be explained by the position the midwives in each institution occupy vis à vis clients, other maternity care practitioners, birthing and postnatal facilities and so on. The most obvious similarity between the continuity/caseload midwifery practices at Burwood and Christchurch Women's hospitals is that the services are provided by CHE-employed midwives. This is significant, in terms of a niche in the market, because of the connection these midwives have with the institution in which the majority of pregnant women still choose to give birth. As CHE-employees, they are located within networks of relations with medical practitioners, CHE obstetrics managers and other CHE staff which enable them to organise their practices in particular ways.

Of particular importance, in terms of the competition between various groups of midwives for clients, are the opportunities that CHE-employed midwives have for aligning their continuity/caseload practices with those of general practitioners and specialist obstetricians associated with the hospitals. For the continuity midwives at Burwood, relations with general practitioners are crucially important because of the part doctors play as gatekeepers to birthing services. While clients can obtain information and advice on maternity options from midwives as well as doctors, many consult initially with general practitioners. This gives general practitioners considerable influence over the choices some pregnant women make with respect to who provides their care and where they give birth. By working collaboratively with local general practitioners who provide limited maternity care, the Burwood continuity midwives not only have access to new clients, but also the opportunity to run clinics in sites other than the hospital.

This opportunity to organise their practice in and across the formal boundaries of the hospital and the general practice clinic is important for midwives operating out of a facility which struggles to attract a sufficient number of births. As a low-tech birthing unit in a semi-rural suburb, Burwood is competing with several inner-city hospitals/facilities for clients. These providers, which include a hospital which used to offer private maternity services but is now contracted to provide primary maternity services within the public sector, offer a range of 'attractive' birthing and postnatal facilities (see chapter eight). Competition from these more centrally located providers, as well as independent midwives, means the Burwood continuity midwives need to spread their professional net as widely as possible if they are to capture clients.

While the Burwood midwives draw on their relations with local general practitioners in an effort to establish a niche in the market, the caseload midwives at Christchurch Women's Hospital utilise their relations with specialist medical practitioners associated with the level-three base hospital. By highlighting their association with obstetricians, anaesthetists and paediatricians and forms of emergency intervention, the midwives constitute their maternity practice as complementary to that provided by specialists. This not only helps to distinguish their service from those offered by other groups of midwives, including other CHE-based continuity of care midwifery services, but also makes it attractive to those clients who either choose or require the services provided by obstetric consultants.

In analysing the introduction of continuity/caseload midwifery services within two public hospital sites, this chapter has highlighted the significance of changes in institutional and funding arrangements which make the development of new forms of professional practice possible. It has provided further evidence for the argument made in chapter six that opportunities to pursue/advance professional interests emerge out of

national policy changes and local responses to those changes. In the case of CHEs/hospitals, the opportunity to reorganise midwifery services and compete for clients within the primary maternity market came as a consequence of midwifery autonomy and the introduction of a fixed-fee funding arrangement. The new forms of public hospital-based midwifery practice that developed out of this conjuncture of factors were dependent on the market and the relational arrangements in which they were embedded.

Public hospitals were not the only maternity providers to take advantage of new opportunities to enter the primary maternity market. The introduction of more competitive contracting into this sector created opportunities for private providers, some of whom were previously denied access to public funds, to bid for contracts. Chapter eight highlights this consequence of the health/maternity reforms by examining the entry of two private sector organisations into the market for publicly-funded primary maternity services in Christchurch. In each of these sites, new forms of midwifery practice were organised around offering clients access to birthing and postnatal facilities that were superior to those in the public health system. Like the public/independent providers, these organisations utilised material and discursive resources in making their services attractive to the Health Funding Authority and potential clients.

## **Chapter Eight**

### **Birth as a public/private business**

#### **8.1 Introduction**

By introducing competitive contractual relations into the primary maternity sector, state actors created opportunities for new and different providers to enter the market. The diverse range of contractual arrangements that the RHAs engaged in with providers from both the public and private sectors aimed to offer consumers/clients more choices in styles of service delivery and to further contain the costs of services. Among the various new providers to enter the primary maternity market were independent practitioner groups, some of which contracted on the basis of interprofessional team care, and private sector medical/maternity organisations.<sup>1</sup> Like self-employed and public hospital providers, they sought to distinguish their services from other competitors in order to secure a niche in the market.

The contracts that these new providers signed with the RHAs were, like those negotiated by public hospitals/CHEs, a variation on the national Section 51 Maternity Notice. While the contracts differed in terms of payment arrangements, they shared an obligation to provide primary maternity services in which an allocated or elected lead maternity care provider (LMC) assumed responsibility for the provision of continuity of

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<sup>1</sup> The most striking example of an interprofessional team approach is a Wellington company called Matpro which involves over a hundred private/independent maternity practitioners. This company signed a contract with the Central RHA in September 1996 to provide medical and midwifery maternity services from Wellington City to Kapiti Coast. An advantage for practitioners belonging to large group/team contracts is that the group, rather than the individual practitioner, holds the budget and therefore the financial risk involved in providing the services.

care to a client. How the various new providers went about organising and promoting their services was contingent on a variety of factors including the patterns of relations and opportunities for the mobilisation of resources within their organisations/practices. Of particular significance was their location in the market vis a vis clients and other maternity care providers/facilities.

This chapter focuses on the development of midwifery/maternity services by two 'private' providers who entered the market for publicly-funded primary maternity care in Christchurch as a consequence of new contracting opportunities. One of the providers is an obstetric unit located in an established hospital in the private health sector; the other is a private licenced birthing centre set up by a group of independent midwives. What the two providers have in common is that they offer clients different forms of maternity/midwifery care organised around access to birthing and postnatal facilities which differ from those available in the public hospital system.<sup>2</sup> While funded by the state, these facilities offer forms of comfort associated with private, rather than public, health services.

In other ways these two providers are very different. While the midwife-owned and operated birthing centre was a newcomer on the primary maternity scene, the surgical/obstetric hospital used to provide private maternity services. With a dwindling demand for private maternity care, hospital management has taken advantage of the new contracting environment to repackage the hospital's maternity services for a public clientele. As quite different alternatives to other facility-based primary maternity services, these new providers have intensified the competition for clients. Small, low-risk birthing units in hospitals on the outskirts of the city, such as Burwood and Lincoln, have been most affected by the introduction of these services.

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<sup>2</sup> Self-employed midwives can access the birthing and postnatal facilities at the obstetric unit for their clients if they have obtained an access agreement. They do not have access to the facilities at the midwife-run birthing centre.



Examining the services offered by these 'private' maternity providers presents another opportunity to consider how different forms of professional practice emerge at the intersection of specific funding regimes and institutional arrangements. It was as a consequence of national policy changes relating to the funding and provision of health/maternity services that these local providers had the chance to enter the primary maternity market. This chapter looks at how the discourse of midwifery as autonomous professional practice and the notion of partnership exist in interaction with state funding strategies and different forms of service delivery to produce different experiences of professional midwifery practice.

## 8.2 Avonlea Birthing Centre

... we are a year down the track now and I think all those who were sceptical at first have had to acknowledge the fact that we are still here and have smiles on our faces - though we have a few more grey hairs - but that we have done it (Avonlea midwife (1): 2.11.94).

The Avonlea Birthing Centre in Christchurch has the distinction of being the first midwife-owned and run birthing centre in the country.<sup>3</sup> Located in an old Avonside homestead, it was opened by five midwives in July 1993. These midwives, who worked together in the maternity unit at Burwood Hospital, formed a partnership and bought the Gloucester St property as the site for a "maternity service with all the safety facilities of a hospital but the atmosphere of a home" (*The Press*, 28.7.97). Advertising for the centre emphasises the privacy and comfort afforded by the surroundings: "The whole focus here is immediately apparent from the soothing pastel decor and the comfortable furnishings". Descriptions of a tranquil garden setting

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<sup>3</sup> A second midwife-owned and operated birthing centre, River Ridge, was subsequently opened in Hamilton.

highlight the home-like environment and position the centre as a "caring and comfortable" alternative to other public birthing facilities.

The decision to set up a midwife-run birthing centre came out of the midwives' involvement in the struggle to keep the low-tech birthing unit at Burwood Hospital from closing. When the future of that maternity service looked uncertain, the midwives felt there was a need to set up another alternative to the services provided at Christchurch Women's Hospital. Their experience of providing continuity of care through the midwives' clinic at Burwood prompted them to consider other opportunities for autonomous practice. As two of the midwives explained:

We had mooted the idea of doing something ourselves. The political climate was right. We had our autonomy and we had learnt quite a lot about health care providers and purchasers and what they were looking for. We looked at what they said and said we can actually do that - let's go and do it. That was the first step in the dark and then we went on a very steep learning curve (Avonlea midwife (2): 2.11.94).

I think that (working in the midwives' clinic) was what whetted our appetite and enabled us to see that we could do this and we could do it our way - and improve on what was going on at Burwood. The philosophy was there - we just built on what we had started there and extended it here (Avonlea midwife (2): 2.11.94).

After protracted negotiations the midwives obtained a private hospital licence from the Ministry of Health and a contract with the Southern RHA to provide primary birthing services. This contract, which is renegotiated every two years, funds the Avonlea services on the basis of a global fee per case.<sup>4</sup> When it was initially negotiated, self-employed midwives and general practitioners were claiming on a fee-for-service basis from the maternity benefits schedule for the care they provided. This funding arrangement was not suitable for Avonlea because the midwives had to cover the costs

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<sup>4</sup> Details of this contract are confidential because of the competitive nature of relations between maternity care providers.

associated with running their own birthing facility and providing clients with a 24-hour postnatal stay. They could also not afford to be paid retrospectively as it would have caused serious cashflow problems for the business.<sup>5</sup>

The midwives found setting up a venture, which was not only new to them but also the purchasing authority, a demanding exercise. While they received considerable support from the Southern RHA, there were bureaucratic hurdles to overcome.

We bought this house and I guess in our naivety thought we should put up a sign and open the front door and it would all happen. But it took a good 18 months to get off the ground. We had no idea what we were letting ourselves in for. There was heaps of red tape and money and blood, sweat and tears that had to go into it... particularly when you are dealing with a bureaucracy that has no blueprints for what you need to do to establish a birthing centre (Avonlea midwife (1): 2.11.94).

It was a huge business experience... we now have heaps of people knocking on the door and ringing up trying to pick our brains but we are very reluctant to say too much. We had to do it all ourselves and a lot of it is commercially sensitive now. We don't have any problem with people setting up birthing centres because we think it is the way to go but we have to think very hard about divulging some of what we've learnt (Avonlea midwife (1): 2.11.94).

While some of the difficulties that the midwives encountered arose because of the novelty of their enterprise, paradoxically other problems related to their more traditional approach to birthing. As practitioners who believed that childbirth was a normal physiological process which could/should not occur according to a timetable, they had to try and run a business around its unpredictability. This was particularly demanding when they were endeavouring to staff a facility as well as provide antenatal and postnatal services in clients' homes.

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<sup>5</sup> The Avonlea midwives resisted pressure from the Southern RHA to begin claiming under the section 51 funding arrangement when it was introduced on July 1, 1996. They did not want the "hassle" of having to claim for various components of care and being paid retrospectively. Their contract pays per trimester - in advance of the care being provided.

It's not like running a heart surgery unit where you can say we'll do x-number of operations, we'll schedule them all in. We've got x-number of staff so we know exactly how we are going. You can't do that with midwifery. Midwifery is one of those totally unpredictable things and it is all on or all off. It is not nice and balanced. We can't say we have 20 clients this month so we will have one every second day. You can't do that and even if you wanted to do it... it would not be good... it would be the wrong view on what childbirth is. It would give clients and women the wrong idea about what it is (Avonlea midwife (2): 2:11.94).

Avonlea began by offering total midwifery care as well as shared care with a woman's general practitioner. If the doctor did not do deliveries, an Avonlea midwife would share care to 28 weeks and then take over the care. Like their counterparts in the Burwood birthing unit, these midwives put a lot of effort into trying to establish good working relationships with general practitioners. This was particularly the case when the centre opened and they were keen to develop a client base.

In those early days we went around a lot of GPs and introduced ourselves and told them that we are going to be here and that we'd share care. We actually worked hard at trying to establish a good working relationship. We got varying responses from them (Avonlea midwife (1): 2:11.94).

General practitioners who wanted to share care with an Avonlea midwife were required to sign an access agreement to ensure they provided services to the client which were consistent with the centre's philosophy and standards. This access agreement identified working in "partnership with women to maintain and enhance the normal childbirth process" as central to the centre's philosophy. The standards of practice included developing a partnership with the woman, providing a holistic service which empowers women to care for themselves and their families, maintaining optimum health in pregnancy and detecting any deviations from normal and referring for additional care if

necessary. The access agreement stated, in relation to developing a partnership with the woman, that "a relationship of trust ensues with a full sharing of information".

The detail of this agreement reinforced the fact that Avonlea was organised on midwives' professional terms. As owners and operators of the facility, these midwives could ensure that the maternity care provided by themselves and general practitioners conformed with the model of practice that they supported. This model, which is promoted by the NZCOM, involves practitioners working in partnership with the client to enhance the normal process of childbirth. The midwives' terms or conditions of practice were articulated formally in documentation such as the access agreement and informally in relations with general practitioners, for example:

We always insist on two pairs of hands at a delivery and obviously if it is midwife-only it will be the primary midwife and one other. If it is shared care it is usually the primary midwife and a GP. But two midwives tend to do a hell of a lot more of the work than a midwife and a GP. So one or two of them (GPs) have been told to bring their pinnies to help clean up, make the cup of tea... (Avonlea midwife (1): 2.11.94).

Avonlea practice is therefore organised around the midwives' understandings of what, for example, partnership and shared care involve. An issue that highlighted differences between the midwives and some general practitioners' understandings of what these concepts mean in practice was that of a 'replacement' practitioner at a shared care delivery. This situation arose if, for whatever reason, a general practitioner who was sharing a woman's antenatal and birthing care was not available for the delivery. Some doctors took exception to the birthing centre's policy that another Avonlea midwife step in as the second practitioner. They objected to not being able to hand over their care to a medical colleague. The midwives' argument was that women in labour should not have to deal with practitioners that they did not know. Arguments about 'partnership', between practitioners as well as between practitioners and clients, were used by the midwives to support their stance on the issue.

The biggest thing that we demand is that they (GPs) work in partnership with us for the benefit of the woman. And some of them have no idea of working in partnership with anybody (Avonlea midwife (2): 2.11.94).

If they are working in partnership they wouldn't be referring to another GP... (Avonlea midwife (3): 2.11.94).

The ongoing difficulties involved in providing shared care with general practitioners were finally resolved by the midwives deciding not to offer clients' this option. This decision, which was made about 18 months after Avonlea opened, was influenced by the fact that an increasing number of the women wanting to birth at Avonlea were electing midwife-only care. Like their counterparts in independent and CHE/hospital practices, the Avonlea midwives found that a number of women who chose shared care for their first pregnancy opted for midwife-only care for subsequent pregnancies. Reflecting back on the decision not to offer shared care, one of the midwives highlighted the different understandings of what it involved:

Most of the GPs... had no idea what true shared care for the benefit of the client was. They thought it was, as usual, I'll make all the decisions and you do all the work. And the women suffered in the middle of it. They (the GPs) were making decisions that women weren't happy with and they would talk to us about it (Avonlea midwife: 11.9.97).<sup>6</sup>

A significant difference between the Avonlea midwives' practice and that of other groups of midwives is that they are committed to staffing a facility as well as providing care to clients in their homes. The extra demands involved in doing shifts (of approximately 12 hours) at the centre mean that they carry a caseload of only four to five women each a month. After four years of doing all the shiftwork themselves, the

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<sup>6</sup> This comment was made during a second interview with an Avonlea midwife in September 1997.

partners employed another midwife to do 'core' duties during the day. This midwife takes responsibility for running the facility, responding to inquiries and is the second pair of hands at any births that take place (she would eventually have one client a month of her own). Her employment means that the Avonlea midwives, like their domino and CHE/continuity counterparts, are able to do antenatal and postnatal visiting during the day because their clients that have just delivered are being cared for by a 'core' midwife.

The independents use a facility and therefore when they deliver a client and write up the notes... they stay for two hours post delivery and then are away. Although that client is still their responsibility and the core midwife on duty could call them if there is a problem - they know they are safe and sound tucked up in bed and being well looked after - whereas we have had to cover all that (Avonlea midwife: 11.9.97).

Another strategy that the Avonlea midwives have adopted to make their workload more manageable, and enable some regular time off, is to work in teams of two. This means that, while clients have a primary midwife, they know a second midwife well and may have her for the delivery if their main caregiver is on holiday or having a weekend off. This arrangement enables the midwives to take one day off during the week if they are working a weekend. They have also considered employing casual midwifery staff to do some night shifts at the centre when they are particularly busy. This move toward employing staff to supplement their care is partly prompted by the realisation that their clients neither need nor expect them to provide all the care themselves.

I think we started off very idealistic but the reality of what women actually wanted... was continuity of care antenatally and during the delivery. That was what was so important to them rather than total continuity of midwifery care. So long as there weren't shifts and changes during their labour - I think that is what women were asking for rather than total care from go to whoa.

When we are rostered on nights our clients get to meet the other staff - we can't stay with them the 24 hours they are here. They (the clients) are quite accepting of that...

Although we might have started off with stars in our eyes the reality was that we would kill ourselves if we went down that track much longer (Avonlea midwife: 11.9. 97).

These comments highlight the difficulties involved in trying to sustain a continuity of care model of midwifery practice in a context where the practitioners are also providing an alternative birthing facility. Unlike self-employed and CHE-employed midwives, who make use of hospital facilities and 'core' midwifery staff, the Avonlea midwives have to provide back-up support for each other as well as staffing the birthing centre. Organising a practice on this basis demands an extremely high level of financial and personal commitment from the practitioners involved. It is not hard to understand why the Avonlea midwives have found it difficult to recruit new midwives into the practice ("we don't have midwives lining up at the door saying they want to join us").

The comments also highlight an issue, which was evident in the discussion in the previous chapter, about the increasing congruity between what were different approaches to facilitating birth. This congruity involves not only a shift towards continuity/caseload midwifery in a range of sites (including low-risk and high-risk maternity hospitals) but also modifications and/or compromises in the way that these various practices get organised in response to consumer and practitioner needs. For example, the Burwood and Avonlea practices began with similar understandings about what it meant to offer an ideal midwifery service. This service basically involved a midwife providing continuity of care (on an on-call basis) for a client throughout her pregnancy, labour and postnatally. Care was organised around particular assumptions, which were promoted at a college/national level, about what pregnant/birthing women wanted from an independent midwifery service.

In both practices modifications have been made to the independent/continuity model of midwifery care in the light of practice. These modifications, which include working in



pairs in order to ensure some time off and making greater use of midwives working in a 'core' role, have been prompted by feedback from clients and recognition of the demands being made on midwives who provide continuous on-call care. As practitioners/managers have found that some clients do not necessarily want or need all their care provided exclusively by one midwife, changes have been introduced to make the services more flexible and, arguably, more client-oriented.<sup>7</sup> These changes reflect the fact that 'women' as clients are a heterogeneous group with diverse needs and expectations with regard to maternity care.<sup>8</sup>

### 8.3 Public/private maternity unit

A full-page supplement in a September 1995 issue of a Christchurch newspaper announced the opening of a pregnancy centre in a single-storey house near a suburban shopping centre (*The Press*, 26.9.95). Advertisements for the centre stated that free pregnancy, labour, delivery and postnatal care was available from a pregnancy centre midwife and her support team. It was not evident from either the name of the centre or its advertising that it was set up by management at the neighbouring private surgical hospital.<sup>9</sup> This hospital, which provided a specialist/private maternity service for more than 50 years, had been able to offer public maternity services since securing a contract with the Southern RHA in September 1994. This contract is for the provision of normal

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<sup>7</sup> The view that clients are not as concerned about continuity of carer throughout pregnancy and childbirth as are some midwives is supported by British research on the effectiveness of midwifery group practices, MGPs. This research found that women laid more stress on the quality of the care that they received from the MGPs in general and were usually happy to receive care from any member of the team. See Allen et al., 1996.

<sup>8</sup> Recognition of these diverse needs, and the consequences for how the Burwood midwifery practice has been organised, was expressed in the quote from the practice manager Chris Hendry at the beginning of chapter seven. Note her reference to the hospital service becoming "women centred in how we offer our midwifery" in relation to aspects of practice which could be seen as contrary to the model promoted by the NZCOM. This comment highlights the process whereby claims that are made at a national/collective level in support of autonomy get worked out at the local level in relations with clients, other practitioners and so on.

<sup>9</sup> Permission to interview midwifery staff at the hospital was given on the condition that the hospital was not identified in the thesis.

deliveries, postnatal care until patients are clinically fit for discharge, elective caesarean sections and antenatal education classes.

The centre opened with a staff of three midwives who had worked in the maternity unit at the hospital. These midwives provided either shared care, with a woman's general practitioner or obstetrician, or total midwifery care if the general practitioner did not offer obstetric services. They were employed to work a 40-hour week providing this care on an on-call basis (their contracts provided for two days off a week and a month's paid leave a year). According to the hospital's manager of obstetric services, the service was set up in response to the demand from women to have continuity of care from a midwife throughout the pregnancy and delivery. She was quoted in the newspaper as saying: "Women will be able to get to know the person who is going to help them through their labour, with continual and individual care from the same midwife all the time" (*The Press*, 26.9.95).

Women attending the pregnancy centre had the option of delivering in the maternity unit at the hospital at no cost. This 23-bed unit included 13 single rooms complete with their own telephone and television, one twin-share room and two four-bed rooms (a further six single rooms were added in 1997 when the unit was refurbished to create a "peaceful but stylish atmosphere"). Publicity for the hospital's public maternity service identified other services as including a personal television set and parenting videos to help during the first few days with a new baby, a photography service and a maternity bra-fitting service.

While the centre was set up by hospital management to offer continuity of maternity care by midwives, it was also seen as a way of fostering the involvement of general practitioners in obstetrics. According to the obstetrics manager, women who used the midwifery services would be encouraged to keep in touch with their general

practitioners and see them for at least one antenatal consultation (*The Press*, 26.9.95). This determination to involve general practitioners in the maternity services associated with the hospital was taken a step further with the launching of two new care options in April 1997. These options, identified as 'supportive care' and 'co-operative care', were developed to allow pregnant women to maintain a level of contact with their general practitioners. This contact was seen as being difficult to maintain following the introduction of the section 51 funding arrangement in July 1996, as the obstetrics manager explained:

Government funding for maternity care changed last year. It caused a lot of confusion amongst women and has generally made it more difficult for women to get the comprehensive care they want... Because we provide both hospital maternity services and midwifery services we've seen the frustrations firsthand. Our response has been to develop two care options which we believe will make it simpler for women to get what they want (*The Press*, 29.4.97).

In the supportive care option, the general practitioner was the lead maternity carer (LMC) and the hospital was contracted to provide midwifery input during labour and delivery.<sup>10</sup> This care was provided by a team of hospital midwives who got to know the women who were having supportive care through morning and afternoon teas in the maternity unit. The women having this care option were encouraged to develop an individual birth plan with the team midwives - one of whom would be at the delivery. While these midwives worked on rostered eight-hour shifts, an effort was made to provide birthing women with continuity of care from a team midwife during labour. The midwife who attended a woman in labour would also visit her at home in the first 24 hours after discharge from hospital.

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<sup>10</sup> The general practitioner claims the payments as LMC and pays the hospital a negotiated fee for the "support" midwifery care during labour, the in-hospital postnatal care and the home visit undertaken by the midwife in the first 24 hours after discharge.

In the co-operative care arrangement, pregnancy centre midwives (who also provided midwife-only care) were the LMC but women were encouraged to maintain contact with their general practitioners by visiting them during the second half of the pregnancy.<sup>11</sup> This contact with the doctor was continued when he/she came to the hospital after the birth to do the paediatric check. The co-operative care option was promoted by the hospital as primarily for women whose general practitioners had retired from obstetrics but would like some input into their care.<sup>12</sup> In an interview, the obstetrics manager elaborated on the hospital's position with regard to the involvement of general practitioners in obstetrics:

There are very few left now (who do obstetrics) and we feel they have a place in the community still. They are the family doctor and it is nice for them to keep on their obstetric practice with their patient if they want to. So we have tried to provide a service that goes around the GP but is satisfactory to the woman and her doctor. It gives them more choices (Obstetrics manager: 4.9.97).

With regard to pregnant women being encouraged to maintain contact with their general practitioners despite the midwives being the LMCs in the co-operative care arrangement, she said:

That's because GPs want to keep their patients on for longer. They feel that when they lose their patients to midwives their patients sometimes do not go back to them - they go in another direction. So this is really to help GPs maintain their practice (Obstetrics manager: 4.9.97).

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<sup>11</sup> As LMC the co-operative care midwife claims from Health Benefits Ltd for payment for the care provided. The hospital pays the general practitioner a negotiated amount for antenatal visits, the paediatric check and the "mother and baby" check at six weeks.

<sup>12</sup> A pamphlet distributed by the hospital identifies the benefits for the client of this form of care as including: maintaining a link with your doctor so she/he gets to know your new family member, establishing a birth plan with your midwife that you are both comfortable with, getting to know your midwife so that when you come into hospital in labour you are able to relax and concentrate on your labour, involving your doctor immediately afterwards by getting them to do the check on your baby.

The hospital recognised that there was a stage in this 'co-operative' or shared management of a pregnancy when it was appropriate for the midwife as LMC to assume sole responsibility. While it was not specified in documentation on the co-operative care option, the expectation was that the general practitioner would see the pregnant woman twice in the second trimester and the pregnancy centre midwife would assume full responsibility for the care from 28 weeks on. The obstetrics manager explained the division of labour and/or responsibility:

There is a set stage in the pregnancy - if the midwife is going to be the LMC she must take over the sole care. There mustn't be joint care after a certain stage because it becomes confusing for the patient and the midwife. The midwife doesn't get to know her patient well enough. And the midwife puts more hours into it than a GP would. They spend more time getting to know the woman and her family. Whereas a GP is busy and he may see the woman for 10 minutes monthly (Obstetrics manager: 4.9.97).

From the perspective of the pregnancy centre midwives involved in the provision of shared/cooperative care, this notion of a cutoff point where they assumed responsibility as the LMC could be problematic. They cited instances where general practitioners had said things to their clients which they regarded as being their prerogative as the LMC. An example was a general practitioner not consulting with a midwife with whom he was providing cooperative care before telling a client that he thought she should have a second ultrasound scan of the baby. This caused the midwife considerable difficulty as she explained:

... they'll say my GP says I should have another scan. And I'll say well what for... but they've got it in their minds that they need a scan. I have to work really hard to say that there is no indication and you really don't need it. That's when it gets really difficult... The GP hasn't stood back and just done the required antenatal check. They seem to want to get in there and prove that they know as much if not more than we do. That's where the conflict comes in... (Pregnancy Centre midwife (1): 22.9.97).

Like their midwifery colleagues in independent practice and in other maternity units, these midwives experienced frustration with sharing care with general practitioners. The difficulties stemmed from having overlapping jurisdictions. With both groups of 'independent' practitioners recognised as having 'expertise' in primary/normal childbirth, there was considerable potential for conflict. This conflict could arise because of different forms of training and different approaches to childbirth and/or the desire to contest each other's professional jurisdiction. Difficulties were also exacerbated by the fixed-fee funding system which could mean that an LMC, working within a capped budget, might have to meet the cost of another practitioner's request for a procedure such as, in this instance, a scan.

Despite the publicity for the co-operative care option, most of the care given by the pregnancy centre midwives was midwife-only (they estimated that approximately 10 per cent of their clients have co-operative care). For midwives whose preference was to provide 'independent' care, the more clients who chose to have midwife-only care the better.

Our position is that we are midwives and we like to work as midwives in teams providing midwifery-only care. We have to ride this fine line with a management that has a different view (Pregnancy Centre midwife (2): 22.9.97).

Working in teams of two, the midwives take on a caseload of up to 15 women per team each month (on the expectation that they will have to hand over the care of some of these women to secondary maternity services). As well as providing various services at the centre, which is open Monday to Friday (8am to 4:30pm), they look after their women in labour, do postnatal home visits and take turns at being on-call at the weekends. Each team is responsible for working out their on-call roster. By taking turns at covering each other at the weekends they each get one weekend off a month. Containing this work within a 40-hour week can be difficult at times (on-call hours are

not counted unless the midwife is actually called on to work) which is why they have resisted increasing their caseload, as three of the midwives explained:

We are made very aware of our financial responsibility. It is put back on us all the time to make the numbers, to make who we care for, and how many, work (Pregnancy Centre midwife (2): 22.9.97).

The trouble when we set up was that they (management) were looking at some of the independents who were doing huge numbers and said why can't you each do 10 or 12 a month. They don't realise that some of those midwives are not giving so great a service especially postnatally. We said we wanted control over our numbers but we have to work hard at that though. Eventually we did get a figure that they were happy with (Pregnancy Centre midwife (1): 22.9.97).

It's always being challenged. The major downfall though is that if they wanted us to carry those numbers they'd have to double the salary because the girls that are doing those numbers are happy to do an 80-90 hour week because they are filling their own bank account. We are employed to do a 40-hour week or somewhere round about that... (Pregnancy Centre midwife (3): 22.9.97).

Two of the pregnancy centre midwives worked in independent practices before being employed by the hospital. They were mindful of what they regard as "pitfalls" for both midwives and clients in the way that independent practice can be organised. One of the lessons they learnt was to work in pairs rather than as practitioners with individual caseloads. They argued that it is beneficial for both the midwives and the client for the care to be shared between two midwives. From their experience sharing the midwifery care ensures not only that the client knows whichever midwife attends her in labour (in some cases they might share the labour care), but also that they can organise their time off. They consider that this way of organising their practice enables them to meet the needs of both their clients and their employer.

I think we approach it differently in that we haven't come into it as a business thing. We like working in a team and we want to have balance in our lives between work and home lives. We want to work a 40 hour week, like we did on the ward, so it's

balancing a different way of working within a 40-hour week (Pregnancy Centre midwife (1): 22.9.97).

These midwives, like those providing continuity of care in other contexts, have had to find organisational responses to the personal demands of following through pregnancies, births and postnatal care. The development of the strategy of working in pairs is presented as an innovation specific to a particular workplace, but mirrors organisational responses in other locations. The difference for midwives practising in a private hospital is that they have to negotiate their caseload and strategies for managing it with hospital administrators, while Avonlea midwives negotiate with one another.

#### **8.4 Competition, choice and comfort**

Having secured contracts with the Southern RHA to provide free maternity services, Avonlea and the private surgical/obstetric hospital began competing with the CHEs and independent contractors for clients. They could offer pregnant and birthing women an alternative form of maternity care to that provided either in/from public hospitals, general practices or clients' homes. This alternative form of care is organised around access to facilities that would normally be associated with the private health sector. Both providers used the comfort, attractiveness and home/hotel-like qualities of their facilities as an important drawcard for their services.<sup>13</sup> In this respect they share a similar position in the market in that they are public providers who have the advantage of being able to offer clients access to 'private' type facilities.

While these providers are similar in terms of this public/private status, they are significantly different in other ways. Some of these differences relate to how and why

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<sup>13</sup> A newspaper article in *The Press* (29.4.97) described how an interior designer had created a "peaceful but stylish atmosphere" in the hospital's maternity unit. The single rooms were "homely but of hotel quality" so that women could get "maximum pleasure from being with their baby in those first few days".



the particular services were set up. While Avonlea was set up by practitioners to provide a new primary maternity care option, the pregnancy centre and various care options were set up by hospital management to reposition their services in the maternity market. While Avonlea is a relative newcomer on the maternity scene, the hospital had facilities and status associated with its former position as a private maternity service that could be used to attract new business. This was evident in promotional material for the hospital's maternity services. Advertisements said: "Treat yourself. Have your baby at (hospital name) - and it won't cost you a cent" and "(Hospital name) now provides a free maternity service. But it hasn't changed its high standards" (*The Press*, 31.12.94, 29.4.97).

It is evident from the discussion in the case studies that the two practices cater for different but overlapping niches in the primary maternity market. In offering midwifery-only care from a small, midwife-run facility, Avonlea is catering for those clients who want care organised around particular understandings about how midwives and clients can work in "partnership" to maintain and enhance the normal childbirth process. Like other forms of independent midwifery practice, it involves midwives providing continuity of care throughout the pregnancy, labour and post-natally. However, unlike other forms of independent practice, it also involves midwives providing an attractive, home-like environment in which clients can give birth. In providing such a facility, the Avonlea midwives attract clients who would rather labour in a birthing centre than either a hospital or their home.

By contrast, the private hospital/pregnancy centre offers a variety of maternity services which are designed to attract a broader range of clients. In securing a contract to provide public/free maternity care, the hospital managers could develop a variety of services which did not rely, as they had in the past, on only attracting those clients who could afford private/specialist care. With access to state funding for the services they

now provide, it is in the managers' interests to develop services which attract as wide a range of clients into the hospital as possible. This determination to attract pregnant/birthing women who would not previously have had access to the hospital, and could have felt deterred by its private status, was shown by the decision not to explicitly link the hospital name with that of the birthing centre.

One way of appealing to a wide range of clients is to develop maternity services that offer a lot of choice both in terms of who provides the care and how that care is provided. This concern with offering clients choice is evident in advertising for the private hospital's maternity services which outlines the various options that clients have. These options range from choosing what birthing practitioner (or combination of practitioners) the client may want to choosing what position is best for labour, what meals she may want from the menu and what rooming-in arrangements she may want postnatally. It is partly because the hospital was set up as a private maternity facility that it is able to offer some of these choices. An advantage it has in occupying this public/private position is that maternity clients have the opportunity to switch from being a 'public' client to being a 'private' client. For example, clients have the choice of extending their postnatal stay as a paying patient.<sup>14</sup>

In competing against other providers for postnatal clients, the hospital has the advantage of being able to offer hotel-away-from-home facilities. While some women and/or their maternity caregivers may choose a hospital that provides a full range of obstetric services for a birth (this hospital only provides elective caesarean sections), they may want to transfer to more relaxed and comfortable surroundings for their postnatal care. With the module system of funding primary maternity services, there is

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<sup>14</sup> A more recent example of the blurring of boundaries between public and private maternity services was the establishment of a luxury postnatal suite for fee-paying clients in the country's largest public maternity hospital, Auckland's National Women's Hospital. This unit was opened amidst criticism that it would undermine the publicly-funded facilities that the hospital offered. (Revington, 1999).

a financial incentive for the hospital to provide this component of care.<sup>15</sup> This was shown by the introduction of a free taxi service for women wanting to transfer from Christchurch Women's Hospital to this hospital after the birth of their babies. This service, which involved the use of taxis from the firm Corporate Cabs that came complete with a baby's car seat, was provided courtesy of the hospital.

The introduction of this transfer service, plus the co-operative and supportive maternity care options, can be seen as initiatives adopted by hospital management to not only attract clients but also the support of doctors. As the midwives' interview material highlighted, the services promoted most strongly by hospital management are organised in such a way as to offer choices to general practitioners as well as clients. This is most evident in the co-operative care option which is designed to involve general practitioners, who have retired or withdrawn from obstetrics, in the provision of antenatal care. The hospital's promotion of this "shared care" arrangement is significant given that it has been the most difficult option for clients to access, and for midwives and doctors to negotiate, since the introduction of the fixed-fee funding of primary maternity care. By facilitating the involvement of general practitioners in shared care, hospital management was not only making this maternity option available, but also fostering relations with these primary care doctors.

Efforts by hospital management to promote services that supported general practitioner involvement in primary maternity care can be seen as another example of the collaborative relations that can co-exist with competitive relations within a quasi-market in health (Flynn and Williams, 1997). As a primary maternity care provider that employs midwives to provide independent care, the hospital is competing with general

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<sup>15</sup> According to the modular funding arrangements, women who are transferring to another facility for their postnatal care need to arrive within 12 hours of the birth if they have had a normal delivery and within 48 hours if they have had an epidural or caesarean section. The payment to the hospital for providing three days of inpatient postnatal care is \$280 per woman.

practitioners and self-employed midwives for clients. However, as a primary maternity facility, the hospital has an interest in collaborating with independent contractors who have a significant influence over where their clients choose to give birth. By collaborating with these contractors, the hospital hopes to attract extra clientele - and the funding that accompanies them.

Promoting the involvement of general practitioners in maternity care is understandable in a hospital which is primarily concerned with providing private surgical services. As gatekeepers to these services, general practitioners play an important role in referring patients to specialists associated with the hospital. This is very different from the situation at Avonlea where the involvement of general practitioners was limited to the provision of shared care for relatively few clients during the first 18 months. Once the birthing centre was established, and the midwives could fill their caseloads with clients wanting midwife-only care, then there was no need to provide shared care with general practitioners. Given the difficulties the midwives had in trying to make this arrangement work for themselves and their clients, it was not surprising that they decided not to continue offering shared care as an option.

The fact that the Avonlea midwives could decide not to continue with shared care highlights an important difference between their position and that of the midwives employed to provide 'independent' midwifery care at the private hospital. In their capacity as both owner/managers and practitioners at Avonlea, the birthing centre midwives have considerably more control over how they practise than midwives working at the private hospital. As hospital employees, the pregnancy centre midwives are obliged to provide whatever services that management decides are in the best financial interests of the hospital. While they may prefer to provide midwife-only care, they are required to share care with general practitioners who choose, or whose clients choose, the co-operative care option.

Comments from interviews with these midwives show the tension inherent in their situation and that of other midwives employed in hospitals to provide 'autonomous' care. As practitioners with the legal right to practise independently of doctors, they can be employed by hospital management to offer continuity of midwifery care on their own responsibility to a caseload of clients. Providing such a service would satisfy the hospital's contractual obligations with regard to catering for normal deliveries. However, as hospital employees, these midwives can also be called on to provide other primary maternity services. Hence the possibility of having to practise in conjunction with general practitioners whether they want to or not.

The case studies in this chapter also highlight the different demands that groups of midwives have to negotiate depending on where and how they choose to practise. For the pregnancy centre midwives, some of these demands relate to management concerns about the range of services offered by the hospital and the number of clients that could or should be catered for. As midwives employed to provide continuity of midwifery care within a 40-hour week, they have some flexibility in how they organise themselves to provide that care. However, they are still accountable to their employers for caseload numbers and are put under considerable pressure to ensure that the financial side of their practice is viable (which includes covering the running costs of the centre).

The Avonlea midwives have to manage the demands that come with not only running an independent midwifery practice but also staffing a birthing facility. While these midwives may have more autonomy when it comes to deciding how and with whom they provide maternity care, they do not have the advantages of guaranteed caseloads and incomes and an approximately 40-hour working week. Having committed themselves financially and professionally to providing continuity of care from a midwife-run facility, they have to cope with demands on their time and energies which

are very different to those of either their self-employed or hospital-employed colleagues. Not only do they face a risk of their maternity 'business' not succeeding, but also the possible failure of a pioneering midwifery initiative.

### **8.5 Doing midwifery differently**

Close attention to two 'private' maternity initiatives in a particular city illustrate both the success of the midwifery model of continuity of care and the significance of the particular organisational context within which midwives practise professional autonomy, partnership with women and continuity of care. Avonlea midwives used shared care with general practitioners at a time when it was favoured by some clients and was useful in building up the reputation of the centre. They could abandon it for professional reasons when they found it to be inconsistent with their practise of partnership. Midwives employed as salaried staff by a private hospital have much less control over decisions about sharing care, despite articulating similar orientations to midwifery-only care.

The midwives whose experience has been presented in this chapter encounter similar challenges to others operating out of public hospitals or as independent practitioners. They have to find organisational solutions to the implementation of the ideal of continuity of care and the need for 'core' midwifery services. These cases highlight how the implementation of the midwifery model of practice can be facilitated by certain forms of state funding and the location of midwives within particular sets of relations with medical practitioners, contract/hospital managers, midwifery colleagues and clients. Midwives may strive to do professionalism 'differently' from other health professionals, but at the same time will differ among themselves in how they do professionalism depending on whether they are self employed or salaried workers employed by larger health enterprises.

## Chapter Nine

### Concluding comments

Cross-cultural study shows that midwives are respected to the extent that they can offer some way (be it technological, spiritual, or some combination of these) to reduce risk and uncertainty... Where they are the primary managers of the risk of birth, midwives have high status. Where other practitioners offer 'better' means of risk reduction *or* where birth is redefined as a less risky event, midwives lose status (DeVries, 1993: 143).

#### 9.1 Introduction

This chapter draws to a close a particular story about midwifery professionalism in Aotearoa/New Zealand in the 1990s. This story has presented midwifery autonomy as a complex and contingent outcome of a competitive political process involving key groups of actors in the maternity/health care field. Unlike stories that regard professional status simply as an outcome of an occupation's organisational structure or political strategising, this account has sought to tease out the complexities involved in the relational construction of professional positioning. In doing so, it has paid attention to how gender, profession/state and profession/consumer relations can be utilised as resources in a particular context. A concern with the specifics of times and places in which struggles over professional status occur also distinguishes this story from those that make generalised, and potentially erroneous, claims about the likelihood of 'success'. See DeVries (above) as an example of such a generalisation.

A focus on the relational construction of professional identities has meant that patterns of interaction between various groups of practitioners, professional leaders, maternity consumer representatives and state actors have been central to the plot. It was out of

shifting and changing relations among these groups of actors, who were embedded in networks of relations at both national and local levels, that opportunities for midwifery to enhance its jurisdiction over the provision of maternity services emerged. Of particular importance in terms of opportunities to contest and/or defend jurisdictions were changing relations between the various professional groups involved in the maternity field and state actors (politicians and policy makers). Policy changes relating to the funding and provision of health/maternity services had major implications for patterns of professional control.

This story has not just been concerned with details of structural changes within the maternity field. It has also paid attention to discursive struggles among various practitioner and maternity consumer groups over the meaning of childbirth. Central to these struggles has been contestation over the meaning of concepts such as 'normal' and 'abnormal' childbirth, 'safety' and 'risk'. Of particular interest have been the discursive strategies employed by midwifery leaders and practitioners to disrupt understandings about the production and use of 'expert' knowledge. Midwifery has been analysed as a site where a new kind of professionalism, based on more equitable professional/client relations, was being asserted.

While this story focussed primarily on the reconfiguring of relations within the maternity field as a consequence of the Nurses Amendment Act 1990, it had its beginnings in the early decades of this century. As a story about professionalism as a path dependent process, it was concerned with historical changes in jurisdictional arrangements that shaped possibilities for action and change in the present. As Tilly (1997: 12) succinctly explained: "... historical accumulations of experience crystallize in shared understandings about future possibilities that then guide current social interaction...". A contemporary story about changes in patterns of professional control over childbirth must therefore include discussion of contestation between midwives,



doctors and state actors in the 1930s. Forms of autonomy or jurisdiction become embedded in the structure of health/maternity systems and, while contested, continue to influence current practices.

The substantive focus of the story constituted through this thesis has been on how midwifery has been doing professionalism 'differently' in a context of health sector restructuring. This has involved key groups of actors both within and outside of the profession in efforts to develop and institutionalise an alternative view of pregnancy/childbirth as a 'normal' physiological process that was most appropriately managed by those with 'expertise' in midwifery. An important strategy in this complex political process was the articulation of particular claims about gender and professional/client relations to position midwives as the most appropriate providers of primary maternity services. Midwifery advocates used gender as a resource in constituting midwifery as a 'partnership' between female birthing practitioners and women who shared their birthing philosophy.

In gaining the right to practise independently of doctors, and claim from the state for the services they provided, midwives in Aotearoa/New Zealand came to occupy a central role in the maternity system. Unlike many of their counterparts overseas who worked independently but in the private sector, midwives assumed a central role in the publicly-funded maternity system. As either independent contractors or salaried hospital employees, they could assume responsibility for the antenatal, birthing and postnatal care of women with normal/low-risk pregnancies. Opportunities to enhance this jurisdiction over primary maternity services came with the introduction of a payment system that encouraged the provision of continuity of care throughout pregnancy, birth and postnatally by a single practitioner.

## **9.2 Putting autonomy into practise**

This thesis has shown that professional autonomy is neither complete nor secured once and for all, but is subject to ongoing contestation and negotiation. Discussion of how jurisdiction over the provision of maternity care came to be dominated by doctors in the 1930s, and contested by midwives in the 1990s, highlighted the contingency of professional autonomy. The jurisdictional arrangements governing the provision of maternity services were dramatically undone by the Nurses Amendment Act 1990. In enabling midwives to practise autonomously, state actors not only removed the medical profession's legal monopoly over maternity work, but opened that sector of health care up to competition. After decades of dominating the provision of maternity services, doctors found themselves competing with midwives for a share of the primary maternity market.

Midwifery's struggle for autonomy, and subsequent efforts to consolidate its new professional status, demonstrated the significance of a profession's relations with the state. As discussion in chapters three and five highlighted, the state has played a crucial role in constituting, reproducing or diminishing the jurisdiction that midwives and doctors have had over the provision of maternity services throughout this century. Through legislation governing the regulation and funding of maternity services, state actors have supported different professional claims over the provision of birthing services depending on broader health policy concerns. With regard to midwifery autonomy, state actors supported the introduction of an alternate primary maternity service which promised to be more cost-effective, flexible and consumer-oriented than medicalised maternity care.

Analysis of state actors' support for midwifery autonomy provided the basis for an argument made in the thesis that the success or failure of a profession's efforts to advance or consolidate its interests was contingent on those claims being compatible with broader political and economic objectives. In the case of midwifery autonomy, claims about the distinctiveness and desirability of a midwifery model of care were compatible with state actors' interests in promoting more cost-effective and consumer-oriented primary health services. This meant that discourses of efficiency, accountability and consumer choice could be drawn on by both midwifery/consumer representatives and state actors in support of midwifery autonomy. It also meant that unlikely alliances, such as that between feminist health/birthing activists and Treasury officials, were possible.

The significance of the role played by the state in either enhancing or diminishing a profession's opportunities for autonomous practice was also demonstrated in discussion of the shift from a fee-for-service to a fixed-fee system of funding primary maternity services. This analysis showed how the specifics of funding arrangements had major consequences for medical and midwifery autonomy, forms of practice and relations with clients. The adoption of a fee-per-case, modular payment system, in which a contracted practitioner effectively held the budget for a client's care, undoubtedly advantaged midwifery. Not only did this funding arrangement discourage more general practitioners from providing maternity services, but it also encouraged more midwives to assume responsibility for the provision of a client's full care.

The argument was not that state actors set out to extend midwives' jurisdiction over childbirth vis à vis general practitioners through this change in maternity funding policy. Midwifery's opportunities to enhance its position in the maternity field arose as a consequence of the strategies adopted by state actors to resolve the problems they faced with regard to the funding and provision of primary maternity services. While

state actors anticipated cost savings by enabling midwives to practise autonomously, this goal was undermined by a fee-for-service payment system which facilitated the duplication and over-provision of services. Given the need to contain costs, and resolve some of the interprofessional difficulties associated with shared care, it was in state actors' interests to introduce a funding regime involving fixed fees and a lead maternity care provider (LMC).

While the analysis in this thesis highlighted the importance for professional status of decisions made at a national level, it did not suggest that policy changes were implemented in a consistent (top down) way. To the contrary, it drew attention to the diversity of responses to policy changes from practitioner groups and health/maternity institutions at a local level. Analysis of the development of various forms of maternity/midwifery practice by both independent and CHE/hospital providers showed how they were influenced by particular configurations of relations between medical and midwifery practitioners and the groups with which they were closely associated. It was from different positions within the market vis a vis clients, facilities and other practitioners that the various providers endeavoured to secure a niche for their services.

Case studies of new organisational forms for providing midwifery care in the 1990s highlighted their dependence on the networks of relations, institutional settings and funding regimes within which they were embedded. Changes in these arrangements produced changes in the various forms of professional practice. This was demonstrated most graphically by the growth and subsequent decline of shared care, involving self-employed midwives and general practitioners, as a primary maternity option. As a collaborative form of maternity practice, shared care depended on the involvement and support of midwives and doctors. This involvement largely depended on practitioners, particularly doctors, receiving financial remuneration that they considered appropriate,

not only for the time and effort they put into providing care, but also their knowledge and expertise.

The shift to a fixed-fee funding regime was a critical event in the reconfiguring of the maternity field. Not only did Section 51 contribute to more general practitioners withdrawing from primary maternity care, enabling self-employed midwives to increase their influence, but it also provided a means whereby hospital-employed midwives could assume a more central role. As maternity hospitals/CHEs took advantage of the new funding arrangements to set up continuity/caseload midwifery services, opportunities were created for midwives employed by these hospitals to assume greater control over their practice. As LMCs, these midwives were contracted to provide continuity of care to a caseload of clients. Like their self-employed colleagues, they could exercise considerable discretion over how they organised their practice (although not over the size of their caseload).

The development of continuity/caseload midwifery in different types of maternity hospitals - base and low-tech, urban and rural, public and private - had important consequences in terms of increasing midwifery's jurisdiction over primary maternity services. Most importantly, it meant that midwives employed in institutions where the majority of women still chose to give birth could not only assume responsibility for client care, but also practise according to the model of midwifery care that was promoted by the NZCOM. In providing continuity of care, on either a midwife-only basis or in conjunction with doctors, hospital midwives were offering a similar service to their self-employed colleagues. This meant that midwives' capacity to practise 'independently' was no longer simply tied to their employment status.

While midwives' employment status became less significant, similarities and differences in the contexts in which they were practising became more significant. As

more maternity providers in both the public and private sector offered continuity of midwifery care, competition for clients increased. This put the onus on providers to make their services as attractive as possible to particular groups of maternity consumers. Analysis of various sites where new forms of midwifery practice were developed highlighted similarities and differences that arose from the relations in which midwives and/or doctors were embedded and the facilities or resources to which they had access. How these new forms of professional practice were constituted depended on particular configurations of practitioners and their location vis a vis other health professionals, obstetrics/funding managers and birthing facilities.

At one level there was increasing homogeneity (isomorphism) among primary maternity services as a variety of providers - ranging from independent contractors to public hospitals to licensed private birthing centres - offered continuity of care from a single practitioner (with backup support). However, at another level, there was increasing diversity as providers endeavoured to distinguish their services and find a niche in the market. For example, while a private sector provider advertised its 'hotel-away-from-home' postnatal facilities, a base maternity hospital promoted the specialist medical services that were offered in conjunction with one-to-one midwifery care, and a birthing centre appealed to those who wanted the equivalent of a home birth but in a midwife-run facility. In each of these settings midwives were located in different patterns of relations with other midwives, general practitioners, obstetricians, managers and clients.

### **9.3 Doing gender, expertise and partnership**

Midwives' professional status rests entirely on our partnership with birthing women; our role as independent birthing practitioners is to put the responsibility back onto women so they can retain control and power over what happens to their bodies (Guilliland, 1993).

A key strategy identified in the thesis as contributing to midwifery's changing professional status was the articulation of particular claims about gender, expertise and professional/client relations to position midwives as the most appropriate providers of primary maternity care. Analysis of how midwifery has been constituted by midwives and maternity consumer representatives within the NZCOM as a form of feminist professional practice showed how particular constructions of gender and expertise could be used as discursive resources in the struggle to obtain and consolidate autonomous status. This feminist form of practice was based on a 'partnership' between midwives as female health professionals and women who shared their understanding of childbirth as a 'normal' physiological process.

The adoption of a gendered model of 'partnership' as a means of enhancing midwifery autonomy was possible in the context of Aotearoa/New Zealand in the late 1980s due to the availability of global discourses associated with feminism, consumerism and 'new' forms of professionalism. These discourses were drawn on by midwifery leaders, educators and practitioners to (re)constitute midwifery as an autonomous form of maternity practice (rather than specialist nursing practice) and to undermine the social relational monopoly of control that doctors had over childbirth. Within the context of bicultural relations in Aotearoa/New Zealand, 'partnership' could also be understood as involving certain principles of knowledge and power-sharing that had particular relevance because of the Treaty of Waitangi.

Doing professionalism according to this model of practice involved positioning midwives as autonomous practitioners vis a vis doctors and nurses but as 'partners' in interdependent relations with maternity consumers. The implications of this complex arrangement of inter- and intraprofessional relations for midwifery's organisation, training and practice were discussed in the thesis. Research on the introduction of a

direct entry midwifery (DEM) degree programme showed how midwifery educators began to construct a formal knowledge base which underpinned midwifery's claims to expertise in 'normal' childbirth and supported a model of practice in which the client was positioned as a knowledgeable participant. The aim was not to displace 'expertise' but to give it a different meaning.

A model of professional practice which constructed the client as active, knowledgeable and gendered opened up a space for different jurisdictional claims over the tasks or 'problems' involved in maternity work and the knowledge/skill required to 'solve' them. It enabled midwifery to not only challenge the medical profession's definition of childbirth as a potentially risky medical event but also, very importantly in the wake of the Cartwright Inquiry, its positioning of pregnant/birthing women as passive recipients of 'expert' medical services. The model also supported midwifery's definition of childbirth as a normal physiological process in which the woman, rather than the birthing practitioner, was the central actor. This definition underpinned midwifery's claim to having the knowledge and skills necessary to facilitate normal childbirth and to exercise professional judgement over the boundary between midwifery and obstetric practice.

Analysis of midwifery's use of a 'partnership' model of practice to enhance its professional status supported an argument made in the thesis that a distinction between 'old' and 'new' forms of professionalism should be seen as a false dichotomy. The 'new' framework of professional practice was a continuation of the 'old' in that it used a profession's knowledge base, albeit a differently constructed one, to strengthen its position in the labour market. While 'new' professionalism was potentially the basis for more equitable relations between practitioners and clients, it still provided a framework of practice which could be used by a profession to construct its work in a particular way in order to make jurisdictional claims over it vis a vis another profession. In this



sense the reformed model of professionalism, with its different constitution of 'expertise', was strategic rather than 'new'.

This case study has shown that professionalism should be understood as socially situated, both in practice and discursively, and as subject to interpretation and redefinition. Rather than conceptualising a shift from one model or ideal-type of professionalism ('old') to another ('new'), it is more useful to recognise that different forms of professionalism exist simultaneously and can be strategically utilised by professions in ongoing contestation and negotiation over professional status. How a profession uses its knowledge base as a resource in claiming jurisdiction over work that it constructs as a form of 'expert' practice is variable. Opportunities for doing professionalism 'differently' are contingent on a profession's embeddedness in networks of relations with state actors, clients and other professions.

#### **9.4 Looking ahead**

As this account of how midwifery professionalism has been negotiated in Aotearoa/New Zealand over the last decade is concluded, a key ministerial review of maternity services is due to be released. This inquiry was ordered in January 1999 by the then Health Minister, Bill English, because of what he described as an "increasing number of reports about problems with maternity services" in 1998 (Ansley, 1999: 20). The Minister was reported as being particularly concerned about the number of general practitioners who had given up delivering babies. He appointed a high profile television presenter, Maggie Barry, as chair of the National Health Committee (NHC) which undertook the review. The committee's task was to report on how the service was working since the introduction of a lead maternity care (LMC) provider and fixed-fee funding.

As part of its investigation, the NHC invited women who had given birth since the LMC system was introduced to complete a questionnaire which was published in a national women's magazine. This questionnaire asked women if they had been given enough information to choose an LMC and whether they were satisfied with the care they received from their LMC during pregnancy. On a scale from strongly agree to strongly disagree, they were asked to indicate whether they were (a) confident that their LMC would refer them to other maternity providers if necessary, (b) well cared for by the LMC during labour and the birth of the baby, (c) satisfied with the care they and their babies received in the hospital/maternity facility and (d) well supported by their LMC once at home with their babies.

As the profession that provides most LMC services (62 per cent of pregnant/birthing women chose a midwife as their LMC last year), midwifery will obviously come under scrutiny. How this female-dominated profession, which came from relative obscurity to a central position in the publicly-funded maternity system in less than a decade, will fare in this review remains to be seen. It is possible that the report could highlight the various settings in which midwives now practise and how this influences the care that clients receive. Feedback from consumers who completed the questionnaire or made submissions could provide a useful indication of the different experiences that clients had of midwifery care, including similarities and differences in their experiences of the 'partnership' model of practice.

This is a research topic that I have identified as a complement to this study of midwifery professionalism. It was not possible within the scope of this thesis to include maternity consumer 'voices', other than in relation to the politics of partnership. A separate investigation of consumer perspectives on how partnership is (or is not) being put into practise by midwives in a variety of community and/or hospital settings would provide another side to the story of midwifery professionalism presented in this thesis. It would

be an opportunity to examine how organisational factors curtail or enhance the giving of 'women-centred' care by midwives. It could also focus on how midwives and pregnant/birthing women actually 'do' gender through their embeddedness in particular professional/client/family relations. This research could provide a useful counter to assumptions about shared gender status producing shared interests (Sandall, 1996; Benoit, 1995; DeVries, 1993).

Another important direction for research on differences in the way that 'partnership' is constructed by practitioners and clients involves developments in Maori maternity practices. While initiatives in Maori midwifery have not featured in this thesis, for reasons identified in the introduction, they are becoming an increasingly significant aspect of autonomous midwifery practice in Aotearoa/New Zealand. More flexible health service contracting has created opportunities for both Maori and non-Maori midwives to offer services which incorporate traditional Maori birthing practices. Research into how partnership is understood and acted upon in these professional/client relationships could show the complexity of doing gender and ethnicity within new models of professional practice.

## **9.5 The last words**

I think in five years time under this contracting system we should be - if we have worked it right and that is still in the balance - we should be absolutely cemented as an independent profession - contracted separately and in charge of our own destiny (Guilliland, Interview: 8.5.95).

This comment from NZCOM leader Karen Guilliland neatly summarises many of the central concerns of this thesis. It highlights the agency of midwives as an occupational group that has taken advantage of the opportunities presented in a context of health sector restructuring to enhance its professional status. This research has shown how

midwives have played a major role in effecting change not only in their professional position, but also in the way that primary maternity services are provided in Aotearoa/New Zealand. Working in collaboration with maternity consumers, they have contributed to a significant shift in understandings and practices related to childbirth. With the majority of midwives now contracted by the state to provide an autonomous maternity service, Guilliland's prediction about midwifery's position at the end of the decade would appear to be accurate.

What remains to be seen is how much control midwifery has over its "own destiny". As this thesis has demonstrated, professional autonomy is always partial and subject to ongoing contestation and negotiation. While midwives undoubtedly occupy a central position in the publicly-funded maternity system, there are no certainties about how that position, or the system itself, may change in the future. One possibility, for example, is the emergence of a two-tier system in which some clients pay for the primary maternity care of their choice. How this would affect patterns of professional control is impossible to predict. What is certain, however, is that professional jurisdiction over childbirth will continue to be a complex and contingent outcome of shifting relations among midwives, general practitioners, obstetricians, maternity consumers and state actors.

## Appendix One

1. Methodological Appendix
2. Consent form
3. Summary of interviews

## **Methodological Appendix**

The purpose of the methodological appendix is to provide an account of the processes of investigation and interpretation involved in the production of this thesis. Aspects of this account were introduced in the opening chapter of the thesis in the sections entitled 'Constructing midwifery as an object of study' and 'Entering the field'. This discussion explained how I was conceptualising professional activity as embedded in networks of relations – as being constituted by interaction amongst groups of actors in a field – and recognised that this had implications for the theoretical and empirical approach I was using to make sense of it. In this discussion I will reflect on both the research process and the techniques I employed to gather material.

I attended my first New Zealand College of Midwives' conference in August 1994. I had been researching midwifery for just over a year and this was my first opportunity to feed back some of my preliminary findings (Tully, 1994), make contact with practitioners from various parts of the country and solicit further support for my project. Doing a workshop presentation provided a chance to share some of my understandings about what it meant to be a midwife in Aotearoa/New Zealand in the 1990s and to hear responses to these ideas from a group of practitioners, educators and maternity consumers associated with the college. As someone engaged in a feminist research project, I was keen to demonstrate my commitment to research as a collaborative process in which both the researcher and participants contribute their situated knowledges.

The distinction I was making between myself as a researcher on the 'outside' of the midwifery profession, and midwives/maternity consumers as knowledgeable 'insiders' and potential research participants, became less clear-cut during the three-day conference. As a researcher, I understood the importance of feminist politics in midwifery's struggle to gain and consolidate professional autonomy. However, I had not considered the implications of this politics for me, as a woman, undertaking critical analysis of this 'case'. My awareness of potential difficulties was raised one evening during the conference when there was an impromptu concert. As various groups of midwives and/or consumers were cajoled into performing song and dance routines - to much laughter and appreciation from the audience - it became a celebration of women together. As a participant, I was no longer simply a researcher on the 'outside', but also a woman on the 'inside'.

My fieldnotes for the conference recorded my concern about the complexity of my positionings. As a female researcher, who was also a close friend of an established midwife in Christchurch, I had an advantage in terms of accessing practitioners and their understandings about 'doing' midwifery and negotiating autonomy post 1990. This advantage had been compounded by the support given to my project by both the president of the NZCOM, Sally Pairman, and the national director, Karen Guilliland. However, in my position as a sociologist/researcher, I was concerned about the possibility of being 'captured' by the college (not intentionally) as an advocate for midwifery. The challenge was to subject midwifery to critical scrutiny whilst also engaging with midwives in a collaborative form of feminist research.

As the research progressed, there were numerous opportunities for reciprocity and/or collaboration. Both Guilliland and Pairman expressed interest in seeing midwifery's professionalising activities analysed using a sociological approach. As leaders/educators who were involved in crafting midwifery's professional identity

nationally and internationally, they were interested in theories on professionalism and discussion of their relevance for midwifery. For example, Guilliland incorporated some analysis from a research assignment I wrote following our first interview in a paper she presented at the International Confederation of Midwives conference in Canada in 1993 (Guilliland, 1993). Our collaboration extended to the joint authorship, with a maternity activist colleague and fellow doctoral student, of a chapter on midwifery professionalism for a feminist studies text (Tully et al., 1998).

Collaborating on this chapter was a good example of the challenges and rewards involved in doing this form of feminist scholarship. Initially, the idea was to write the chapter as three separate voices - that of a researcher, a maternity activist (involved in the NZCOM) and a midwifery leader. However, the editors eventually preferred a relatively seamless discussion of the issues. As a result, while our different positions were recognised in the introduction to the chapter, our voices were combined in the text. This meant that our account of how midwifery was doing professionalism had to reflect the various understandings that we brought to the subject. This was difficult when, for example, I would analyse as 'strategic' claims that midwives would regard as the 'truth'. The challenge was to ensure not only that we produced a useful examination of the issues, but also that our various positions were not compromised in the process.

Another way in which material produced in the course of this research has been made available to midwives has been through the education system. As a guest lecturer to students in the Masters in Midwifery programme at Victoria University in Wellington, and the Bachelor of Midwifery programme at Christchurch Polytechnic, I focussed on midwifery as a case study in 'new' professionalism. In examining some of the difficulties involved in adopting a 'partnership' model of practice, I highlighted the embeddedness of practitioners within different networks of relations with clients,



midwifery colleagues, medical practitioners and state actors (hospital managers, funding authorities etc). My aim was to show how the diverse positions that midwives occupied within the maternity field contributed to potentially different understandings of what 'partnership' (and 'midwifery', 'autonomy', 'normal' childbirth and so on) meant and different opportunities for practice.

Support for the analysis presented in the lectures, and in the thesis itself, was derived from information generated using a variety of research strategies. These strategies included historical and documentary analysis, interviewing and fieldwork. This multi-faceted approach was appropriate for this research given my understanding that there is no single or 'true' method for acquiring knowledge. Influenced by contemporary feminist theorists (Weedon, 1987; Hekman, 1990; Fraser and Nicholson, 1990), I reject the notion that knowledge is the product of the opposition of subjects and objects and that there is only one way in which knowledge can be constituted. I regard all knowledge as historically situated and as constituted collectively through forms of discourse.

This view of knowledge as partial, located and contextually grounded has significant implications for research. Rather than being a search for 'the' truth about an independent and stable reality, research becomes a means of constructing 'situated' knowledges. According to this epistemology, it is important to recognise the 'locatedness' of all those who participate in the research process, including the researcher (Code, 1995; Maynard, 1994; Acker et al., 1991). Rather than being an impartial observer, the researcher is a knowledge producer who occupies a particular 'subject position'. The knowledge that she produces inevitably reflects the conditions of its production. As Stanley and Wise (1990: 23) note, a researcher's understandings are "necessarily temporally, politically and intellectually grounded" and are therefore as contextually specific as those of the research participants.

I provided an account of my various 'subject positions' in the introductory chapter of the thesis. Briefly, these included being a maternity services consumer, a mother, a support person at five hospital births and a postgraduate student/researcher. From the discussion in this appendix, I can add being a woman, a close friend of a midwife and a collaborator with midwifery and maternity activist colleagues. It should also be noted that both my thesis supervisors have an on-going association with midwifery, nursing and health organisations in the form of policy/education advisors. It was inevitable that the researching and writing of this thesis on how midwifery has been doing professionalism over the last decade would be shaped by the positionings of, and the relations between, those who have been involved in the project in one way or another.

The research participants were selected, or recommended by others via a 'snowballing' process, on the basis of their location within the maternity field. Given my interest in the relational construction of professional identities and forms of practice, I chose to interview members of key groups of actors involved in the provision of midwifery/maternity services. My interest lay in the situated perspective that these actors could offer from their location within particular networks of professional relations, not their representativeness. The groups in which they were located included NZCOM leaders, midwifery educators, direct entry midwifery students, self-employed ('independent') midwives, CHE/hospital-employed midwives, CHE/hospital obstetrics managers, general practitioners, obstetricians and maternity consumer representatives. I did approximately 50 interviews between 1992 and 1998, mostly in Christchurch but also in Timaru, Dunedin and Auckland (see attached Interview Summary). The advantages of basing the study in Christchurch were discussed in the introductory chapter.

Within the various groups identified above, I requested interviews with people whose location within particular sets of relations offered an interesting perspective on changes that were taking place in midwifery/maternity practice. For example, within the practitioner groups I interviewed self-employed and hospital-employed midwives, general practitioners and obstetricians who were involved in new ways of providing maternity care. My interest lay in finding out how the structural relations in which particular groups of midwives and doctors were embedded, and the diverse professional contexts in which they were located, shaped both their definition of themselves as birthing practitioners and their practices. In semi-structured interviews (conducted between 1992 and 1995), I gathered information from these variously positioned birthing practitioners on:

- (a) where, how and with whom they practised, ie. their caseloads, whether they did home and/or hospital births, whether they provided shared care as a birthing option and, if so, how the arrangement was organised
- (b) what their understandings were of 'normal' and 'abnormal' childbirth and what skills they considered necessary and/or appropriate for safe practice
- (c) what their clients' expectations were with respect to the management of their pregnancy and birth
- (d) what involvement they had with others in their professional organisation

Gaining access to the practitioners that I wanted to interview proved to be relatively straight forward. With regard to the doctors, I requested interviews (on the telephone and in writing) with general practitioners and obstetrician/gynaecologists whose practice involved a significant amount of obstetrics and considerable contact with midwives. I was also keen to speak to both male and female practitioners to see if there were any differences in their approaches to obstetric care and working with midwives. All my requests were granted and I interviewed five general practitioners (two female

and three male) and two obstetricians (one female and one male). A female general practitioner and the male obstetrician had been participants in a pilot study for the research that I carried out in 1992. Interviewing them again in 1994 provided an opportunity to update issues discussed previously.

My contact with these medical practitioners was useful for identifying other doctors who may be willing to be involved. The general practitioner was particularly helpful in suggesting other doctors whose practice involved a considerable amount of obstetrics. This information was confirmed by independent midwives I spoke to about the general practitioners who were doing most of the maternity work in the city. Each of the doctors interviewed signed a consent form for participants in the research who were not spokespeople for organisations. This form outlined the ethical procedures that I agreed to abide by to ensure accuracy, confidentiality and anonymity (copy attached). Each doctor received a transcript of their tape recorded interview which they could check and modify to ensure that I had an accurate record of what was said (only one doctor returned the transcript with minor modifications).

Approaching midwives for interviews often involved a less formal process. While some interviews were set up following a telephone request, other opportunities arose unexpectedly. For example, on several occasions when I was at hospital birthing units for a pre-arranged interview with the practice manager, I was also able to interview midwives who happened to be working in the unit at the time. These midwives accepted my assurances that their identities would not be disclosed and that their interview material would be treated as confidential without the need for a consent form. In some cases, they were not concerned about getting a transcript of the interview to check for accuracy. These impromptu and relatively unstructured interviews were supplemented by informal discussions with midwives in a variety of professional and practice settings.

My requests for interviews with obstetrics managers (4) for information on the development of hospital-based continuity/caseload midwifery services also met with approval. These managers were responsible for midwifery practices within hospitals located in the public and private sectors, and in large/urban and small/semi-rural situations. Most of the interviews took place in 1997 after the introduction of the fixed-fee maternity funding system which made the provision of primary midwifery services a more attractive financial proposition for hospitals. I asked each of the managers about how the practices were organised and funded and what clientele they were attracting. Interviews with midwives (6) employed by these different types of hospitals to provide on-call care to a caseload of clients provided various practitioner perspectives on the new arrangements.

Another important group of actors within the maternity field were midwifery leaders and educators, and maternity consumer representatives, who held key positions within the NZCOM. I noted earlier the support given to my research by both the college president, Sally Pairman, and the national director, Karen Guilliland. I interviewed Pairman twice (in 1993 and 1995 in Dunedin) for background information on the establishment of the NZCOM and the introduction of direct entry midwifery (DEM) training at Otago Polytechnic. Like Guilliland, whom I interviewed on six occasions, Pairman provided valuable information on a range of professional and political issues. Both women completed Masters in Midwifery degrees at Victoria University in 1998 and their theses provide useful resources for others researching aspects of autonomous midwifery practice.

To supplement the information given by Pairman and other midwifery educators (3) on developments within midwifery training, I interviewed a group of DEM students from the Bachelor of Midwifery programme at Otago Polytechnic. These students were half

way through their final clinical year and were therefore in a position to reflect on the training they had received and their prospects for future practice. As I indicated in my discussion of the student experiences in the thesis, there is no 'typical' DEM student and selection was therefore made on the basis of difference rather than similarity. I chose to focus on the accounts of training given by two women who were positioned differently from other students in that they were younger, had health/science degrees and had no previous experience of either midwifery or childbirth.

Another valuable source of information on DEM training was a maternity consumer activist/representative who played a leading role in the campaign to get it introduced, Judi Strid. Interviews with Strid in 1994 and 1995, and with several other maternity consumer representatives who were closely involved in NZCOM activities, provided consumer perspectives on developments within midwifery. These interviews were particularly useful in alerting me to some of the difficulties involved in implementing a 'partnership' model of practice at both a professional/client and an organisational level. They also drew my attention to the importance of the standards review committees as a forum where consumers have an opportunity to provide constructive input into midwives' practice. Papers presented by maternity consumer representatives (eg. Strid, 1994; Cole, 1994; Pot, 1994, 1996) at NZCOM conferences also provided a useful resource.

Most of the interviews were semi-structured to allow for flexibility and responsiveness both on my part and that of the interviewees. In most cases the interview proceeded more as an 'informed conversation' than a formal question and answer session which meant that I could make explicit, where appropriate, my 'standpoint' (Holland and Ramazanoglu, 1994) in relation to the research. As noted in the introductory chapter, the interviews were taped and transcribed and participants received a copy of the transcript to check its accuracy. While providing interviewees with a transcript and the

opportunity to correct any inaccuracies did not redress the imbalance of power in the relationship between myself as a researcher and them as participants in my research, it did at least ensure that I had an accurate record of the account they had given me of their experience within the maternity field.

My approach to analysing these transcripts was to recognise them as texts to be read in ways that acknowledge the processes that have contributed to their construction (Friedman, 1995). Hence it was important to identify myself as actively constructing research narratives, rather than being engaged in the transparent transmission of 'authentic' or 'true' accounts of 'real' experience (Armstrong and Du Plessis, 1998). In analysing the transcripts I was concerned with what the participants 'did' with their talk, ie. their discursive practices, and also with the resources that they drew on in the course of those practices (Potter and Wetherell, 1994). This was consistent with my interest in both the narrative and relational construction of social/professional identities (Somers, 1994; Scott, 1992).

Guided by the work of Potter and Wetherell (1994: 17) on discourse analysis, I focussed on how language was used by participants and what was achieved by that use. For example, in defining childbirth as 'potentially risky' and women's obstetric need as 'medical care', doctors could be seen as constructing or positioning themselves as experts and women as the potential recipients of pre-defined services. This definition either excluded non-medical 'experts' from providing particular birthing services or relegated them to practising in a supervised or subordinate capacity. In defining childbirth as 'normal' and women's obstetric need as 'choice and empowerment', midwives and maternity consumers/activists were constituting midwives as facilitators of a particular form of maternity care in which pregnant/birthing women were positioned as agents, actively involved in interpreting their own obstetric needs.

This concern with the discursive strategies employed by groups of actors within the maternity field who sought to either (re)position themselves, or (re)position others, also informed the documentary analysis that I undertook as part of the research process. Differences in understandings about the meaning of concepts such as 'childbirth', 'normal', 'safety', risk', and 'expertise' were evident in statements located in a variety of documentary sources examined in the course of this research. These sources included submissions from various medical, midwifery and nursing organisations and maternity consumer groups; parliamentary debates; Health Department and Regional Health Authority (RHA) reports; professional journals, newspapers and newsletters; conference proceedings; newspaper and magazine articles; unpublished theses and recorded radio interviews.

The submissions and parliamentary debates related to the passage of the Nurses Amendment Act 1990. Submissions to the select committee from the NZCOM, the NZMA, the RNZCOG, the NZNA and the Nursing Council of New Zealand were useful for mapping the positions of the various professional groups with regard to the issue of midwifery autonomy (chapter three). Submissions from various women's health organisations and home birth associations showed the arguments being advanced by maternity consumer groups in support of independent midwifery. Differences between various women's organisations were also highlighted with members of the National Council of Women expressing reservations about midwives being able to practice independently of doctors.

Most of the Health Department and RHA reports that I consulted were concerned with the funding of primary maternity services. The Health Department reports (1992 and 1993) dealt with changes to the maternity benefits schedule as a consequence of midwifery autonomy. The RHA reports (Coopers and Lybrand, 1993; Joint RHA S51 Maternity Review Project, 1995; Southern Regional Health Authority, 1996) outlined



the introduction of new contractual arrangements for purchasing maternity services which were organised around a fixed-fee payment system. These documents, together with policy statements from the Minister of Health and Treasury, provided the basis for an argument about the significance of funding regimes for patterns of professional control.

To trace developments in the negotiations over the Section 51 purchasing arrangements, and responses to their implementation, I collected articles from national newspapers and professional publications throughout 1994, 1995 and 1996. Newspaper articles cited in the thesis appeared in *The Evening Post* (7), *The New Zealand Herald* (5), *Otago Daily Times* (4), *Sunday Star Times* (2), *The Dominion* (1) and *The Press* (4). More in-depth articles on changes taking place in the maternity system were found in general interest magazines including *North and South* (McLoughlin, 1993; Legat, 1997), *New Zealand Listener* (Ansley, 1997; Revington, 1999) and *HQ* (Brett, 1996). These articles, and recorded radio interviews (National Radio, 12/6/96, 13/6/96, 24/6/96, 10/2/97, 11/2/97, 15/10/97, 17/10/97), showed how issues surrounding midwifery autonomy and the reorganisation of maternity funding were being debated publicly by those representing midwifery, medical and state interests.

Regular monitoring of publications produced for doctors, *GP Weekly* and *New Zealand Doctor*, the national newsletters and journals published by the New Zealand College of Midwives and the NZNO journal, *Kai Tiaki*, also provided useful background information on a range of professional issues which informed the questions I asked in interviews and the analysis I constructed in the thesis. Other useful forms of documentary material were NZCOM annual reports and conference proceedings, Bachelor of Midwifery curriculum documents and theses written by midwifery leaders, educators or practitioners who have undertaken masters or doctoral level research (Fleming, 1995; Abel, 1997; Guilliland, 1998; Pairman, 1998).

This multi-strategy approach to the research process generated a wealth of material about midwifery as a field of professional action in Aotearoa/New Zealand in the 1980s and 1990s. By supplementing interview material with information from documentary and media sources, I was able to trace professional and political developments within this constantly shifting field of inquiry. The purpose of utilising these various qualitative methods was not to ensure greater validity of the data or to produce more evidence to support the 'truth' of the arguments presented in the thesis. Rather, the aim was to gather detailed empirical information from which to construct a theoretically informed account of the case. This account acknowledges complexity and contradiction and recognises the possibility of "silences and absences" (Holland and Ramazanoglu, 1994) in the data.

**CONSENT FORM FOR ELIZABETH TULLY'S DOCTORAL  
RESEARCH PROJECT**

I agree to participate in this research project under the following conditions:

1. that I will be provided with a transcript of the interview discussion which I can check and modify to ensure that the researcher has an accurate record of what was said
2. that the researcher treats the interview material as confidential and only allows her thesis supervisors to have access to it
3. that information obtained from the interview will not be used for any purpose other than the researcher's doctoral thesis and conference papers or academic articles
4. that my name will not be used in any written version of the research material; any quotations will be attributed to my professional position rather than me personally
5. that any audiotapes made during my interview will be wiped after the material is transcribed
6. that I may withdraw my interview material from the project at any time

SIGNED.....

As the researcher in this project, I agree to abide by the ethical procedures listed above in order to ensure accuracy, confidentiality and anonymity.

SIGNED.....

## Summary of Interviews

### Interviews conducted in 1992:

Two self-employed midwives	Christchurch	9/92
General practitioner	Christchurch	10/92
Obstetrician and gynaecologist	Christchurch	10/92
National co-ordinator, NZCOM	Christchurch	10/92

### Interviews conducted in 1993:

President NZCOM, Co-ordinator DEM, Otago Poly	Dunedin	11/93
National Co-ordinator, NZCOM	Christchurch	11/93
Co-ordinator midwifery diploma, Chch Polytechnic	Christchurch	12/93
Consumer representative, NZCOM national cttee	Christchurch	12/93

### Interviews conducted in 1994:

Chairperson, Auckland branch, NZCOM	Auckland	2/94
Consumer/co-ordinator, midwifery standards review committees/NZCOM	Auckland	2/94
Consumer/ PEAC member, DEM degree programmes	Auckland	2/94
Three midwives, CHE and self employed	Christchurch	5/94
National co-ordinator, NZCOM	Christchurch	7/94
General practitioner, Pres. O and G Society	Christchurch	10/94

Practice manager, Burwood Birthing Services	Christchurch	10/94
Midwifery manager, Jean Todd Maternity Unit	Timaru	10/94
Continuity of care midwife, Jean Todd Maternity Unit	Timaru	10/94
General practitioner	Christchurch	11/94
Three midwives, Avonlea Birthing Centre	Christchurch	11/94
Obstetrician and gynaecologist	Christchurch	12/94
Obstetrician and gynaecologist	Christchurch	12/94

#### **Interviews conducted in 1995:**

Life member, NZCOM	Auckland	1/9
General practitioner	Christchurch	2/95
General practitioner	Christchurch	2/95
General practitioner	Christchurch	3/95
National director, NZCOM	Christchurch	5/95
Chairperson NZCOM/ Co-ordinator DEM, Otago Poly	Dunedin	7/95
Head Nursing/Midwifery dept, Otago Polytechnic	Dunedin	7/95
DEM students, Otago Polytechnic	Dunedin	7/95
DEM graduate, Otago Polytechnic	Christchurch	7/95
Consumer/working group Midwifery Provider Organisation (MPO)	Auckland	10/95
National director, NZCOM	Christchurch	12/95

#### **Interviews conducted in 1996:**

National director, NZCOM	Christchurch	6/96
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**Interviews conducted in 1997:**

Practice manager, Burwood Birthing Services	Christchurch	4/97
Core midwife, Burwood Birthing Services	Christchurch	4/97
Financial Controller, Canterbury Health	Christchurch	4/97
Co-ordinator midwifery services, Christchurch Women's Hospital	Christchurch	5/97
Obstetrics manager, Maternity hospital	Christchurch	9/97
Three CHE-employed, continuity of care midwives	Christchurch	9/97
Midwife, Avonlea Birthing Centre	Christchurch	9/97
Midwife, Lincoln Maternity Unit	Christchurch	12/97

**Interviews conducted in 1998:**

Chair Canterbury/West Coast branch, NZCOM/home birth midwife	Christchurch	2/98
Two self-employed midwives	Christchurch	11/98
Self-employed midwife	Christchurch	12/98

**Interviews conducted in 1999:**

Self-employed midwife	Christchurch	3/99
Course co-ordinators, DEM programme, Christchurch Polytechnic	Christchurch	7/99

## Appendix Two

### 1. Maternity Payments Schedule

## PART B - MATERNITY PAYMENT SCHEDULE &amp; ADMINISTRATIVE REQUIREMENTS

PART "B" MATERNITY PAYMENT SCHEDULE AND  
ADMINISTRATIVE REQUIREMENTS

1.0	<u>MATERNITY PAYMENT SCHEDULE ("MPS")</u>	
1.1	PAYMENT FOR SINGLE SERVICE EPISODES	\$
1.1.1	Information Re Options of Care	10.00
1.1.2	Pregnancy Care	25.00
1.1.3	Urgent Out of Hours Pregnancy Care	45.00
1.1.4	Threatened Miscarriage Services	45.00
1.1.5	Miscarriage Services	75.00
1.1.6	Ultrasound Scans	79.60
1.1.7	Consulting Specialist Obstetrician Services	
	1.1.7.1 First Trimester - First consultation	83.80
	1.1.7.2 First Trimester - Subsequent consultation	41.90
	1.1.7.3 Other than First Trimester - First consultation	108.00
	(including ultrasound budget for both first and subsequent consultations)	
	1.1.7.4 Other than First Trimester - Subsequent consultation	41.90
1.1.8	Specialist Obstetrician Labour and Birth Services	425.00
1.1.9	Specialist Anaesthetic Services -	
	Payment will be made at the rate of \$28.20 per unit under the Relative Value Guide system	
1.1.10	Specialist Paediatrician Services	
	1.1.10.1 Consultation	86.00
	1.1.10.2 Further consultation on the same problem	43.00
	1.1.10.3 Attendance at delivery (additional payment for each half hour or part thereof beyond the first half hour)	76.80
	1.1.10.4 Urgent Paediatrician attendance	129.70



## PART B - MATERNITY PAYMENT SCHEDULE & ADMINISTRATIVE REQUIREMENTS

### 1.2 PAYMENTS FOR LEAD MATERNITY CARER MODULES

The following payments incorporate the provision of specific services which, where ordered by the Lead Maternity Carer or as otherwise allowed for in this Notice, will be paid by the Agency on behalf of the Lead Maternity Carer and deducted from the Module Payment payable to the Lead Maternity Carer. These services are specified in the Service Specifications contained in Part A of this Notice.

<u>MODULES</u>	<u>\$</u>
1.2.1 Registration with Lead Maternity Carer and Care	
Plan development	75.00
1.2.2 Pregnancy Care - Second Trimester	165.00
1.2.3 Pregnancy Care - Third Trimester	230.00
1.2.4 Labour and Birth Services	
1.2.4.1 Labour and Birth Services - first birth (including multiple births)	950.00
1.2.4.2 Labour and Birth Services - subsequent births (including multiple births)	750.00
1.2.4.3 Supplies and Services for Home Birth	180.00
1.2.4.4 Services at Birthing Unit	100.00
1.2.5 Services Following Birth -	
1.2.5.1 Where woman receives Inpatient Postnatal Care	280.00
1.2.5.2 Where woman does not receive Inpatient Postnatal Care	380.00
1.2.5.3 Rural Home Visit Travel Supplement	
1.2.5.3.1 Category A Where woman's Usual Area of Residence is: Rural and is located more than 30 minutes but less than 60 minutes by Normal Road Transport from the nearest birthing facility	200.00
1.2.5.3.2 Category B Where woman's Usual Area of Residence is: Rural and is located more than 60 minutes by Normal Road Transport from the nearest birthing facility	350.00
1.2.5.3.3 Where there is a specially designated area determined at the RHA's discretion	200.00

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